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PAGE 7

Illinois Medicine

ILLINOIS STATE MEDICAL SOCIETY • JANUARY 17 1997

Cancer
survivors face
more layoffs
than others

PAGE 2

Edgar announces funding for statewide poison hot line

PUBLIC HEALTH: Rush faces heavier burden after closing of Rockford poison center. BY JANE ZENTMYER

[SPRINGFIELD] As of Jan. 1, Illinois poison control efforts received a financial boost of \$250,000 from the state. Gov. Jim Edgar announced Dec. 20 that the state would help fund a toll-free poison information hot line through June 30. The 24-hour hot line, (800) 942-5969, will be staffed by the Regional Poison Control Center at Rush-Presbyterian-St. Luke's Medical Center in Chicago and will be administered by the Metropolitan Chicago Health Council. The Rush center is the only remaining poison control center in the state.

"The poison center is a valuable asset for the people of Illinois," said Earl Bird, president of MCHC. "We are pleased that the state has recognized the value of this service for all of its residents."

Six months ago Swedish-American Hospital in Rockford closed the doors of its poison control center citing financial

problems. Since then, the center in Chicago, which has also faced financial problems, has experienced a 10 to 20 percent increase in phone calls. "The major concern is that people have no way of easy access to a poison center Downstate," said Jerrold Leikin, MD, medical director at the Rush center. "That, to us, is a public health emergency."

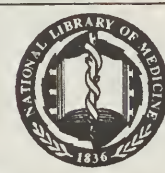
On Jan. 1, the Metropolitan Chicago Healthcare Council assumed control of the Rush center, which previously served the 7.7 million residents of

Cook, DuPage, Grundy, Kane, Kankakee, Kendall, Lake, McHenry and Will counties. With the receipt of state funds, MCHC has agreed to offer services to the Downstate residents who were left without poison control services when Swedish-American closed July 1, 1996, according to the Illinois Department of Public Health.

Local hospital emergency departments in the 93 counties outside the Chicago area have helped pick up the extra load
(Continued on page 8)



John McNulty



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MEDICAL PROFESSIONALS prepare to scan the 120-pound fossilized skull of an animal from the early Eocene era. Participating in the Field Museum of Natural History project last month were Ruth Ramsey, MD, professor of radiology at the University of Chicago Hospitals; William Turnbull, PhD (left), a lecturer at the university; and technician Dale Eggleston.

Illinois Supreme Court will consider tort reform challenges

Judge in Best case strikes down entire statute

BY JANE ZENTMYER

[EDWARDSVILLE] As early as spring the Illinois Supreme Court could begin considering a judge's decision that struck down as unconstitutional all provisions in the 1995 tort reform statute. "This is the first [case] to reach the Supreme Court that deals with the entire statute," said ISMS General Counsel Saul Morse. "It is very significant because it will be [the justices'] first opportunity to deal with everything that's included within the tort reform legislation."

Madison County Judge David Herndon made his ruling in August 1996 in Best vs. Taylor Machine Works et al., a products liability case that challenges the constitutionality of the entire tort reform legislation, according to court records.

More than 70 cases have been filed statewide challenging the constitutionality of various aspects of the tort reform law, Morse said.

The Best case stems from an incident in which Vernon Best was injured in a forklift accident, according to court records, sustaining second- and third-degree burns on 50 percent of his body, bilateral comminuted

fractures of both heels with operative reduction and internal fixation. Best filed suit on various counts against several entities including the forklift manufacturer, the Mississippi-based Taylor Machine Works, and Best's employer, the Alton-based Laclede Steel Co.

Herndon found unconstitutional not only the product liability provisions but all of the medical malpractice aspects of the tort reform statute. The judge ruled that the law violated the separation of powers doctrine in the Illinois constitution, whereby the courts, the legislature and the executive branch each have separate legal powers, and one branch cannot attempt to usurp the powers of another, Morse said.

"One need look no further than the preamble of the act to determine that the express intent of the legislature was to usurp the powers of the judicial branch," wrote Herndon in his opinion. "Likewise, the manner in which the bill was presented makes it clear that this act represents a unified vehicle to take from the judiciary the substance and the procedure for handling
(Continued on page 11)

Attorney general is 'intervenor' in Kunkel case

BY WENDY ANDERSON, JANE ZENTMYER

[SPRINGFIELD] The Illinois attorney general's office has been granted status as an "intervenor" in Kunkel vs. Walton, a case before the Illinois Supreme Court that challenges amendments to the Petrillo doctrine. The amendments were part of the comprehensive tort reform law passed in 1995. The status allows the office of Illinois Attorney General Jim Ryan to file a brief in support of tort reform as well as to argue the case, according to ISMS general counsel Saul Morse. Ryan's office announced it also plans to defend the constitutionality of tort reform in the Supreme Court appeal of Best vs. Taylor Machine Works et al.

The Petrillo doctrine prevents defendant physicians and their attorneys from ex parte communication with plaintiffs' former treating physicians unless the plaintiffs' attorneys are present or have consented to the com-

munication. The 1995 law modified the doctrine so that plaintiff attorneys are required to provide written consent authorizing the release of their client's medical records within 28 days of requests. Failure to do so can result in a court order to obtain the records or dismissal of the case. In Kunkel, Sandra and Ronald Kunkel sued several doctors for alleged gynecological negligence, according to court documents. After the defendants submitted a consent form for Sandra Kunkel to sign, the plaintiffs moved for a protective order quashing the consent on the ground that the tort reform provision was unconstitutional.

The trial court granted the order and declared unconstitutional those portions of tort reform that say that parties to a lawsuit who claim personal injury must permit their medical history to be disclosed at a pre-
(Continued on page 11)

INSIDE

State offers
advance
directive stickers
for driver's
licenses



PAGE 3

DEPARTMENTS

News Briefs.....2
Commentary.....4
ISMIE Update6
Classifieds9

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Cancer survivors face more firings, layoffs than others

[NEW YORK] Cancer survival rates are reported to be at an all-time high, but workers with cancer are fired or laid off five times more often than other workers, according to a 1996 national survey.

The random telephone survey polled cancer survivors and supervisors and co-workers of cancer survivors. Seven percent of the cancer survivors said they were fired or laid off from their jobs as a result of their illness, according to the survey conducted by CDB Consulting Inc. on behalf of New York City-based Working Woman magazine and Amgen, a global biotechnology company. In contrast, the most recent data from the U. S. Bureau of Labor Statistics shows that about 1.3 percent of U.S. workers

received pink slips in 1995.

Employment is a key factor for cancer survivors, the study showed: Eighty-one percent said their jobs helped them maintain their emotional stability during their battle with cancer.

Many cancer survivors face discrimination from bosses who overestimate the side effects of the cancer medications. For example, 85 percent of the supervisors said they believed fatigue was a side effect, but just 58 percent of the survivors said they actually experienced fatigue. Similarly, 74 percent of supervisors said nausea was a problem for workers undergoing cancer treatment, but only 33 percent of the survivors reported having been nauseated.

New medications for treating nausea and other side effect, as well as preventing life-threatening infections, have vastly improved the quality of life for many cancer survivors in the past decade and can keep people on the job longer. But some supervisors are unaware of those advances, the survey said.

Recent reports of a five-year drop in overall cancer deaths suggest more employers will need to shed old prejudices about workers with cancer. Philip Cole, MD, and Brad Rodu, MD, of the University of Alabama, reported that overall cancer death rates have shown a sustained decline for the first time since 1900, reported the Chicago Tribune. Experts attributed the decline to preven-

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Telemedicine conference to be held next month



The Illinois Rural Health Association's first annual telemedicine conference – "Telemedicine in Illinois: What Can it do for You?" – will help physicians take advantage of new technologies. The conference will be held Feb. 18-19 in Springfield and is co-sponsored by ISMS, the Illinois Academy of Family Physicians, the Illinois Area Health Education Center and the Illinois Hospital & HealthSystems Association.

Topics will include legal considerations for telemedicine consultants, the use of telemedicine for continuing medical education and scheduling considerations when using the Internet. Exhibits will feature the equipment and applications used in telemedicine.

"It will be a wonderful opportunity to meet others who have an interest in using telemedicine to meet their particular practice needs, to talk to equipment vendors and to hear speakers from other parts of the country who already have systems in operation," said Mary Ring, chief of the Illinois Department of Public Health's Center for Rural Health.

The conference will be held at the Hilton Hotel at 7th and Adams in Springfield. Before Feb. 1, registration costs \$50 for IRHA members and \$65 for non-members. After that date, fees increase \$10 for members and nonmembers. Participation is limited to the first 225 registrants. To get a registration form, call the IRHA at (800) 500-1560.

tive measures, especially anti-smoking efforts, and to improvements in early detection and treatment, which have increased the chances of surviving many common cancers.

Their analysis, originally reported in the journal Cancer, shows that the overall cancer mortality rate, adjusted for age, dropped each year from 1990 to 1995, for a total decline of about 3.1 percent. In 1990, the death rate peaked

at 135 deaths for every 100,000 people. The rate then fell annually, reaching 129.8 deaths per 100,000 in 1995, or five fewer deaths per 100,000 than in 1990.

"The 1990s will be remembered as the decade when we measurably turned the tide against cancer," said Richard Klausner, MD, director of the National Cancer Institute, according to the Tribune story. ■

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State offers advance-directive stickers for driver's licenses

COMMUNICATION: Another option exists for patients to make their wishes known. BY DAVE WIETHOP

[SPRINGFIELD] Although most Illinoisans are aware of the organ donation notification found on the back of state driver's licenses and identification cards, they may not know about the possibility of using an equally important notation: advance directives.

Secretary of State George Ryan's office has offered stickers indicating that the holder of the license or state ID has a living will and/or power of attorney in place. The small, green star stickers displaying a caduceus can be placed in a designated spot in the upper right-hand corner of licenses or state IDs and tells emergency medical personnel to look for another state-issued card that contains information about the holder's advance directives.

The wallet-size advance directive card provides the individual's name and address, the location of the living will and power of attorney, and the dates that the power of attorney begins and ends. The card also provides space for the names and telephone numbers of three people who should be contacted in an emergency, as well as the name and telephone number of the cardholder's physician.

lic doesn't know about the cards and stickers. "Most people know the organ donation card but not about this," said one Downstate driver's license facility employee. "Maybe people really don't feel comfortable

about talking about living wills and things of that nature [at the driver's license facilities], so perhaps they feel more at ease talking about them with their doctors."

An issue related to notification of advance directives is the veracity of the information. Because driver's licenses and state ID cards are renewed every four years, some physicians say much can happen in between the initial decision about advance directives and the time the documents are needed.

"These are not static wishes," said Phillip Boren, MD, of Carmi, chairman of ISMS' Council on Medical Services.

"Much can happen in the time it takes to renew your license, and you may not have the same desires when it comes time to enact these directives."

For physicians who would like to discuss advance directives with their patients, ISMS offers the kit "A Personal Decision," which can be distributed to patients and includes an explanation of directives as well as living will and durable power of attorney forms. For ISMS members, the first 300 copies are free. Single copies are available to the public at no cost, and bulk orders can be purchased. To order the kit, call (312) 782-1654 or (800) 782-ISMS, ext. 1221. ■



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REPORT

for Illinois Physicians

QUALITY: THE KEY TO SUCCESS

Like any company, Blue Cross Blue Shield of Illinois (BCBSI) must meet the expectations of its customers. We consider our most important customers to be purchasers (usually employers or the government), members (patients), and providers (physicians and other professionals, hospitals and other institutional entities). In general, in selecting among insurance arrangements, these customers look for affordability and quality. Quality can be seen as comprised of a number of components: good clinical process and outcomes, accessibility to a wide variety of sources of health care, and ease of participation in the insurance arrangement.

Not all customers place the same weight on these various expectations. For some purchasers, economics dictate that affordability is the pre-eminent value. For others, one or all of the components of quality may be equally or more important.

To be competitive, BCBSI must offer insurance arrangements which meet these expectations. We do so through a number of product options. Traditional or indemnity arrangements, the PPOs (PPO+, Community Blue), the POS (MCNP/BlueChoice), and the HMOs (HMOI, Blue Advantage) are the principal options in our commercial business. These products differ in how and to what extent they meet the various priorities which our customers set.

Over the past decade or two, competition in health insurance has largely centered on affordability. Managed care owes much of its growth to the priority which many in the market have placed on this value. Increasingly, however, the focus of competition, and of public policy, is widening to the domain of quality.

The manifestations of this are many. Patients are demanding more information about the performance of health plans and the providers in them. In selecting these plans, they are seeking greater choice and ease of participation. They are looking to their legislators for, or their legislators are seeking to engage them with, mandated participation requirements. Employers are expecting accreditation and health plan "report cards" which attempt to measure various aspects of clinical process and outcome in addition to member satisfaction and service performance. Providers are seeking plans which offer simple arrangements for getting authorizations for services and receiving payment for them.

BCBSI believes that, over the long run, competition will increasingly center on quality, and that good quality will increasingly be a primary means of achieving affordability.

At this time, the science underlying the measurement and demonstration of quality is at an early stage of development. There are a number of attempts on a national level to measure various aspects of quality: the report card ("HEDIS" or "FACCT") efforts, outcomes measurement coalitions, specialty society databases, etc. BCBSI supports these activities, and participates in them whenever possible. We also promote them in our business relationships with providers. As we continue to redefine our relationships with you in the future, our ability to support your efforts to deliver and measure quality will improve. We continue to invest in increasingly sophisticated data collection and measurement tools, always vigilant to see that the information we produce is clinically meaningful and honest. We believe that these activities are crucial to our mutual future success.

Issue: 1/17/97 - AMK

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Notification and Information Card
(Notificación y Tarjeta de Información)

LIVING WILL and/or POWER OF ATTORNEY for HEALTH CARE
(TESTAMENTO y/o CARTA PODER DEL CUIDADO DE LA SALUD)

Living Will (Testamento) ☐ Power of Attorney-Health Care (Carta Poder-del Cuidado de la Salud) ☐

Name (Nombre): _____

Address (Dirección): _____

Physician (Doctor): _____

()

FILL OUT THIS CARD AND CARRY ON YOUR PERSON
(COMPLETAR ESTA TARJETA Y LLEVARLA CONSIGO)

The cards and stickers are available from the secretary of state's office and are free, which means the state has little opportunity to track how many have been distributed, according to secretary of state spokesperson Dave Urbanek.

ISMS policy encourages people who have durable power of attorney and/or living wills to carry a card stating that these documents exist and where they are on record. It also recommends that hospitals and physicians implement those documents as authorized by the state of Illinois. At ISMS' 1996 Annual Meeting, a resolution was adopted reinforcing the importance of placing advance directives information on driver's licenses and state IDs.

A quick survey of some driver's license facilities emphasized that the pub-

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EDITORIAL

Aging painfully

On Jan. 3, a young Chicago man was charged in court with the fatal beating of his 87-year-old grandmother. The story behind this one-line blurb – relayed through a news service fax – may never grab media attention, but it has impact nevertheless because it isn't an isolated case. In Illinois, reports of elder abuse have nearly doubled since 1991, according to the Illinois Department on Aging. Reported cases jumped from 2,053 in 1991 to 5,276 in 1996. In about 80 percent of the cases, the abuser is a family member.

The victims typically have several difficulties to deal with, according to the department. In fiscal year 1995, 56 percent were nonambulatory; 42 percent were functionally impaired; 29 percent were disoriented; 27 percent had hearing problems; 21.6 percent had Alzheimer's disease and 18 percent had vision problems. Almost three-quarters suffered from one or more of these challenges.

The abuses may take different forms: financial, emotional, physical or sexual, or involving passive neglect, willful deprivation or confinement. Victims usually experience more than one type of abuse.

To confront the problem, the department is doing more than tracking numbers. Since April 1991 it has administered an intervention program to respond to abuse allegations. The program is locally coordinated through 40-plus provider agencies that conduct investigations and work with older

adults to resolve abusive situations.

Physicians should be aware of possible instances of abuse and neglect of the elderly, according to ISMS House of Delegates policy, which also encourages reporting suspected cases. The AMA offers a handbook, Diagnostic and Treatment Guidelines on Elder Abuse and Neglect, to help physicians recognize elder abuse and neglect in various clinical settings.

In addition to being potential victims of abuse, older adults are at highest risk for suicide, according to University of Illinois researchers who conducted a 1996 study on suicidal behavior among this age group. A disturbing finding in suicide literature is that as many as 75 percent of older adults had seen a physician shortly before their deaths, said one of the researchers.

The U of I survey was mailed to 800 physicians in internal medicine, family practice and geriatric psychiatry to determine the extent of their training in recognizing and addressing symptoms of suicidal behavior. Before the study was sent to respondents, it was reviewed by ISMS' Council on Mental Health and Addiction and endorsed by ISMS. The results will be reported in an upcoming issue of Illinois Medicine.

Older adults tend to consult their physicians about depression and loneliness, so doctors have the opportunity to screen, treat or refer them and help alleviate some of the pain of aging.

PRESIDENT'S LETTER

Outcomes research

Sandra F. Olson, MD



Doctors have long proved they can incorporate, utilize and react to solid information.

Physicians have always used the results of good, sound, scientific research and observations in their care of patients. Now we have a new type of research in medical practice that does not involve laboratory animals or test tubes, but uses opinions, the measurable results of treatments and the functional health status of patient populations. Performance measures derived from clinical practice guidelines are also incorporated to accurately assess the applications and quality of health care services. It has been estimated that only 9 to 12 percent of what we as physicians do is truly validated, according to Robert A. Browne, MD, senior health outcomes research consultant at Eli Lilly & Co.

For many years doctors assumed they gave good quality care – and by and large they did. However, changing demands by employers and other purchasers of health care have forced the medical profession to measure quality in some objective fashion. Systems such as the health plan employer data and information set, or HEDIS, have been developed to attempt to provide this type of information. Disease prevention and management, along with cost containment and value for dollars spent, are the end points for such programs. This type of paradigm is patient- and outcome-focused. Its proponents believe that in this way medical intervention and providers can monitor their processes of care and thereby continuously improve performance.

Patients' satisfaction and opinions about the quality of life also enter this matrix. The quality of life has been defined as "the functional status as a result of personal health." Patient satisfaction questionnaires have long been used by hospitals, doctors and other health institutions to provide feedback on care. We are all familiar with them and have probably received a copy commenting on ourselves at one time or another. These forms are increasingly becoming more sophisticated and standardized. However, do they really pro-

vide meaningful data? People who use them certainly think so and are willing to pay for this information. In other words, the data-hungry purchasers of health care are no longer taking our word for value and quality and care being given in a particular setting. They are clearly wedded to the Deming precept "In God we trust, all others must bring data." That brings us to information management, the fundamental building block of this whole process.

Doctors have long proved they can incorporate, utilize and react to solid information. They can be flexible and change habits and behavior when presented with reliable feedback. It is occasionally painful and difficult, but we do it regularly. After all, we are lifelong students of our art and science. But it's important that we not forget our patients' input into this equation. The author E.D. Pellegrino has said health "depends as much on the patient's assessment as the physician's. If full restoration is not possible, then amelioration of suffering, adaptation or coping with chronic or fatal illness becomes the end of the healing relationship." We still adhere to the precept "Treat the patient, not the disease."

We consciously – and unconsciously – challenge our internal, private, medical decision-making on a daily basis. We weigh facts and information about a patient, estimate the relative value of these components, discard the irrelevancies, ask more questions when gaps exist and rate the data in order of importance. So actually, in our own built-in computer – called the brain – we go through an "outcomes research" process that is not codified as such. But it is no longer enough to say what works. We must provide evidence, and as doctors, we must be integral in this new research process. As William C. Nugent, MD, chairman of cardiothoracic surgery at the Dartmouth Hitchcock Medical Center, said recently, "To be effective stewards of our practice, we have to measure our outcomes. But it should be something that's done by us, not to us." All aboard.

GUEST EDITORIAL

A letter to Lara

By Robert R. Raszkowski, MD

Reprinted from the South Dakota Journal of Medicine 1996; 49:409-410.

Dr. Raszkowski read this letter at the May 1996 graduation ceremony at the University of South Dakota School of Medicine.

My vantage point this afternoon is a unique one, as both a parent of a member of the class and a faculty member. And it is from that dual perspective that I would like to read a letter to my daughter, to share some thoughts with her. Now this letter might be, I hope, equally applicable to anyone in the class and as such, it might begin Dear Cathy, or Kenton, or Brian, or Holly, or Dawn, or Tom, but this one begins

Dear Lara,
When you started medical school I promised I would try to stay out of your education during the time you were a medical student. I hope that for the most part I have done that. But your class had afforded me a unique opportunity, a cherished one, to speak to them and to you on this very special day. Here, then, are some of the things I would have said in the last four years.

First, how proud your mother and I are to be here today. We hope we have had some insight into what you put in to get here, but only you and your classmates know what it took for each of you. While your medical education may have almost fully occupied your time and devoured your resources for now and into the future, I hope you will find joy in your work. Medicine is a wonderful profession.

We are privileged to be with those we serve at the extremes of life's emotional scale: the birth of a long-awaited child, the sorrow associated with prolonged illness or an anticipated loss, the grief of a sudden, unexpected death.

Don't be afraid to show your emotions, to linger, to comfort, to hold a hand. There is no DRG or ICD-9 code for showing that you care.

Talk to your patients and remember to talk to their families too. Osler was right. If you listen to patients and their families, they will tell you enough to make most diagnoses. While there is an ever increasing armamentation of advanced diagnostic techniques to help you make diagnoses, the experienced clinician usually uses the history to make the diagnosis in the most cost-effective way.

Medicine is ultimately about people. Despite all the scientific advances, ultimately you and your patient come together to make decisions, and that partnership is vital. As the health care delivery system changes rapidly around you, remember that you must remain the patients' chief advocate. Do not allow your billing department, your practice group, an insurance company, an HMO or a governmental entity to interfere with the doctor-patient relationship. It must remain a sacred trust.

I hope you will consider becoming a

teacher, not because that was my choice, but rather because medicine depends upon an apprenticeship model. Without those who gave of their time, especially the volunteer faculty throughout this state, you would not be here today. Remember to learn what not to do. Where you saw your future colleagues in medicine to be good role models, emulate them. When they weren't, remember that "25 percent of learning is learning what not to do."

And remember to teach your patients, too. That time investment will make your job significantly easier, because they will have the knowledge to become partners with you in their care.

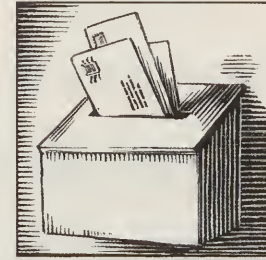
Continue to be an active learner. You have just spent four grueling years in medical school and will spend an additional four years in a demanding residency. But hopefully, you will have the opportunity to spend 40 years in practice. And continuing medical education will need to carry you through those 40 years. Commit now to keeping your knowledge up to date.

A few weeks ago you admitted to me that you didn't think you knew very much. That's certainly what almost all of us felt when we graduated from medical school. You're at the right place, because you recognize what you don't know. While residency and continuing education will help correct that feeling, there will always be individuals who are more knowledgeable than you. Seek them out, wherever they are, and use them as your consultants.

Be critical of yourself. On the way home at night quietly ask yourself how you could have done it better. And then act on your assessment the next day. In business it is known as continuous quality improvement, or CQI. To me, it is just a simple way by which you can improve

Confidentiality when patients are kids

The article "Maintaining patient confidentiality" (Oct. 11 issue) was fine as far as it went, but it did not take into consideration the age of the patient. I am a child psychiatrist, and I am sure that any physician who treats children encounters the same type of problem that I do. It is impossible to get the patient's consent to communicate information to third parties, so the parent acts on behalf of the child. That is fine as long as both



parents agree, but they don't always agree.

A more difficult situation occurs when the patient is an adolescent who may object to the doctor's communicating with an interested third party such as a school, but the parent wants that information communicated. In addition, if an adolescent sees a physician without parental knowledge, it creates the problem of what to tell the parent, especially if the issue is pregnancy.

— Helen R. Beiser, MD
Chicago

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For those whom you work with and who need to change, counsel them in private and praise them in public. If you felt uncomfortable when you were belittled in a learning situation, don't perpetuate this negative part of a medical education.

If you are lucky, many others will help you succeed. And when others help you do something well and you are acknowledged publicly for this, step aside and let them have or at least share the spotlight.

Today's health care is more and more becoming a partnership. Many are there to help you care for your patient and add their expertise. Welcome them for what they can add, but never forget that when the iceberg is dead ahead, it will be lonely in the wheelhouse. You are there as the captain of the ship. Someone has to do it, and that is where your personal strength, your training and your expertise will hold you in good stead.

Be quietly critical of the status quo.

Advances in medicine are rarely made without questioning current doctrine. Continue to think like a scientist.

You will be held to a higher standard than most in our society and rightly so, I believe, as you will be making life-or-death decisions. Live your life and make your moral and ethical decisions as though you were living on the front page of the local paper, because in most communities you are.

Finally, try to contribute your time and your talents to your community and to your new profession. Too frequently we criticize from the sidelines. That is certainly much easier than taking risks by being a participant.

And so, Lara, there it is. It turned out to be simple. Listen, care, question, accept responsibility and share your time and your talents.

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With respect and love,
Dad

Shatter

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ISMIE Update

Risk management can help prevent sexual misconduct allegations

An attorney and physicians recommend chaperones and good communication.

BY DEBORAH PREISER

Nothing can be more devastating to a physician's career than a formal charge of sexual misconduct. These lawsuits are tough to defend and costly to the wallet and the reputation. If the charge is criminal sexual misconduct, malpractice insurance won't cover defense fees. Even in civil cases in which the accuser charges the physician with sexual misconduct, insurance companies will not pay for the doctor's defense unless the case involves an allegation that the doctor was negligent in performing medical treatment.

Physicians can take measures to protect themselves, according to Joe Camarra, an attorney with Cassiday, Schade & Gloor in Chicago. "It's best to conduct all physical examinations with another person, preferably a medical assistant or nurse, in the room. This is especially true with examinations of children and when the physician and patient are different sexes. It's much more difficult for someone to make a claim of sexual misconduct when there's a witness in the room."

Camarra also stressed the importance of good physician-patient communication. "Explain what you're going to do, why you're doing it and what you're looking for. For an Ob/Gyn, pinching a woman's nipple to see if there's any discharge might be perfectly appropriate medical care. If [women] know in advance why the doctor is doing something like this, they are less likely to assume any inappropriateness by the physician." A doctor conducting any exam should communicate with the patient, he added. "Before I have a prostate examination, I want to know what's going to happen."

Yet doctors may sometimes treat the patient as just an extension of the procedure, according to Camarra. "Ultimately, they're going to have to communicate something about their findings.

It makes the patient more comfortable if [physicians] explain what they're doing and what they're finding as they go along, rather than [at] the very end."

"Physicians should conduct themselves in a professional and ethical manner in every situation," said David Cromer, MD, an Ob/Gyn and a member of the ISMIE Risk Management Committee. "Having good rapport with your patient is important. I've never had a patient ask for a chaperone, although I have someone else in the examining room for all women, no matter what their age, if I'm doing their first gynecological exam; for all minors; and for anyone I suspect is apprehensive about the procedure."

Having someone other than the doctor present does create drawbacks, Dr. Cromer said. "I personally think my patients are more frank and ask more questions when someone else is not in the room. I was not trained, nor have I felt the need, to have a chaperone in every situation. At Evanston Hospital and at my clinic, we do require every resident and medical student to have a chaperone present for these kinds of examinations."

Scott Multack, DO, an Ob/Gyn in Downers Grove, has established procedures to make sure a nurse is present for any pelvic examination conducted by him or the two women doctors in his practice, according to Gail Hanzelin, office manager. A nurse accompanies the patient into the examining room, does a preliminary interview, gives the patient a robe and lets the patient undress in privacy. The nurse and doctor are present for the exam, then leave together while the patient dresses. The doctor returns for a confidential discussion with the patient, she said.

"In nine years, no one has ever asked the nurse to leave," said Hanzelin, who was previously Dr. Multack's nurse.



"Some patients will ask ahead if a nurse will be present, especially patients who are child-bearing age."

"I believe having a chaperone present takes the fear away for many women," Dr. Multack said. "If the patient is undergoing a procedure like an endometrial biopsy, she often finds it's very comforting to have the nurse there to hold her hand."

"I also think it's a safety factor to have a nurse or medical assistant present," Dr. Multack continued. "I never want to be accused by someone who has mistaken something I did."

Extra care is taken with young girls before they receive their first gynecological examina-

tion and/or Pap smear, according to Hanzelin. The nurse explains what's about to happen during the pelvic exam and shows the patient the speculum. The doctor also explains what's occurring as the examination progresses.

Camarra advises physicians to stay within their area of expertise. He recalled a case of a dermatologist who performed a vaginal examination on a young girl alone in an examining room; the doctor said he was considering herpes as the diagnosis. The fact that the doctor had never performed a vaginal exam on any other patient, however, would have made his action hard to defend in court.

"If the dermatologist felt a vaginal examination was necessary, he should have referred the girl to an Ob/Gyn for consultation," said Camarra, "or at the very least, had a chaperone come into the room while he performed the exam."

In Camarra's opinion, there's no way to predict which patient is likely to make a claim of sexual misconduct. It's important to remember that this is not a gender issue, he said. "Overwhelmingly, charges of sexual misconduct are made against males, but we have had cases of female physicians accused of it."

"From my experience, I'm convinced that young females who have been the victims of

sexual abuse in the past are more likely to transfer feelings [of rage] from the abuser to the doctor after a physical exam that includes touching," Camarra said. "No physician should think it can't happen to them. It can."

For that reason, doctors should know their rights, Camarra said. "I've had clients who have been in their offices when police show up with a warrant for their arrest. When they got to the police station, almost all were confronted by a representative of the Illinois Department of Professional Regulation who suggested that the doctor cooperate and talk right then."

Camarra's advice: "Don't talk. If you're being confronted with a claim of criminal wrongdoing, you need someone to represent you. You will have to communicate eventually with IDPR, [but] there's no need talk right then."

The key is prevention, Camarra advised. "It costs extra money to have another person in the examining room, or [it] may take more time to explain what you're doing." But that extra effort may help eliminate misunderstandings and potential charges of sexual misconduct, he said. It should also help the patient better understand what the physician is doing and feel more comfortable. ■

MALPRACTICE ROUNDUP

Hospital doesn't owe warning about fainting

A hospital didn't owe a woman a warning that she might faint while watching her 10-year-old nephew receive emergency department treatment for a cut on his chin, according to a Washington Appeals Court ruling reported in the October 1996 issue of Health Law Digest.

The boy was taken to the hospital after falling off his bicycle and sustaining the cut. His aunt was asked to serve as an interpreter between hospital staff and the boy and his father, and to help comfort her nephew. When the physician opened the boy's wound to clean it, the aunt fainted and struck her head on the floor. She suffered a concussion, convulsions, nausea, headaches and other injuries, according to the report, and spent five days in the hospital. She subsequently sued the hospital, alleging that it had a duty to warn her of the risks associated with observing the medical procedure, including fainting.

The appeals court upheld a trial court's ruling granting summary judgment for the hospital. The aunt was considered an "invitee" who entered the hospital for the purpose of getting care for her injured nephew, the court said, and the hospital owed invitees only a duty of ordinary care to maintain the premises in a reasonably safe condition. Requiring a hospital to prevent every non-patient who enters the emergency department from fainting would exceed the level of ordinary care given to invitees, according to the court. The risk of fainting was so well known, the court said, that it shouldn't require a warning: The aunt was in the better position to know whether she would faint at the sight of blood. ■

Seeing the sites while navigating the Net

It's hard to remember life before fax machines. They deliver paperwork within minutes, just as the Internet can put research, clinical news and conference reports at our fingertips. Although you may know that medical information is accessible on the Internet, you may not know how extensive it is.

Physicians can find up-to-the-minute synopses of clinical research, debate on ethical issues, contact with patients who have questions, even advice about investing. Thanks to World Wide Web sites like the one sponsored by ISMS, doctors can even contact their legislators directly.

A Melrose Park-based Ob/Gyn admits he's fascinated by the resources on the Internet but hasn't fully taken advantage of them. "I can look for continuing education courses on-line and then check out the hotels nearby," said Scott Pierce, MD, who has been on-line for about eight years. "When I'm on vacation, I can check messages on the e-mail systems from the hospitals I'm affiliated with, instead of having eight hours of follow-up when I get back home. And I'm able to keep in contact with patients who are on-line themselves."

Although Dr. Pierce said he could use the Internet more, physicians who surf the Net at all are in the minority. Only about 110,000 physicians, or one-sixth of the doctors practicing in the United States, are on-line on a regular basis, according to the newsletter *Medicine on the Net*.

At least one Web site, the Doctor's Guide, offers on-line "clips" of articles from medical journals nationwide that can be sent by e-mail 48 times a year for a fee. Several medical news services post substantial, clinically oriented reports at least daily.

Still other Web pages offer discussion groups, "debates" among group members, links to other medical sites and occasional pages geared specifically for patients. For specialists, the Internet offers sites that are broad enough for patient use and others that are fairly specific.

While the scope of the Internet is daunting, a discriminating eye can navigate the estimated 60 million Web sites. Longtime users say the key is to become familiar with what the Internet offers and know specifically what you're looking for before you log on.

THE SIMPLEST WAY to find research-oriented Web pages is to visit the site of a popular search engine. For example, the Yahoo! site is <http://www.yahoo.com>; Alta Vista is at <http://www.digital.altavista.com>; and Lycos is at <http://www.lycos.com>. Look for some key words such as "Hepatitis" and "B." A recent search, which took less than a minute, found about 25 new, primarily clinical references to the virus.

Beyond games and e-mail, the Internet promises a wealth of information.

BY DAVE WIETHOP



You might also find a site that's updated often (some news services are changed three or four times a day) and rely on the Web page links to other sites of interest.

Diagnostic information and patient education materials are primary Internet resources for Mary Pohlmann, MD, PhD, chief of the Women's Health Clinic in the Student Health Programs at Southern Illinois University in Carbondale. "My most reliable source for clinical research remains Grateful Med (<http://igm.nlm.nih.gov>)," she said.

"As the Web develops, it becomes increasingly important to be able to identify the veracity of information presented," she explained. "Health information available through any mass media is

replete with anecdotal stories and unsubstantiated claims, and the Web is no different. Thus, I find it important to confirm the source and authority behind various Web sites. Nonetheless, there is some very fine information available for the professional as well as patients."

Any concerns, however, are easily outweighed by the benefits of going on-line, according to industry experts. Many day-long Internet courses are offered by area colleges, universities and training organizations.

When you're ready to start surfing, the following are some sites to hit:

- ISMS at <http://www.isms.org> provides the full text of the Society's survey of HMOs that conduct business in Illinois and recent press releases. Direct e-mail links to state legislators who have Internet access are also included.

- The Doctor's Guide at <http://www.pslgroup.com> is updated daily and offers medical news for physicians – including summaries of major papers presented at recent conferences as well as a guide to meetings and continuing education.

- The List of Lists for Medical Sites at <http://www.arcade.uiowa.com> helps physicians find other medical Web pages. The site has been compiled and is maintained by the Hardin Library at the University of Iowa College of Medicine in Iowa City.

- MD Gateway at <http://www.mdgateway.com> is devoted to daily news updates geared for physicians.

- The Medical Matrix at <http://www.slackinc.com/matrix> is a good starting point for medical searches.

- The Medical Tribune at <http://www.medtrib.com> offers news services for family physicians, internists, cardiologists and Ob/Gyns. This site also encourages debate on its "Physician Faceoff" bulletin board.

- The Medical World Search at <http://mwsearch.poly.edu> and Medsite Navigator at <http://www.medsite.com>

(Continued on page 8)

Seeing the sites

(Continued from page 7)

MedsiteNavigator.com are two fairly new medical search engines.

■ Medicine on the Net at <http://www.mednet-i.com> links to medical sites, question-and-answer sessions and discussions. It's sponsored by Medicine on the Net newsletter.

■ The Physician's Guide at <http://www.physicianguide.com/pgi> offers a wealth of clinical news and links to sites concerned with "physician well-being," such as family life and finance.

■ SuperDoc's Home Page at [http://](http://www.harbornet.com:80/folks/superdoc)

www.harbornet.com:80/folks/superdoc offers a broad assortment of medical links.

■ Virtual Hospital at <http://indy.radiology.iowa.com.edu/virtualhospital.html> is geared for medical professionals and patients and includes physicians' resources.

"Doctors who are taking advantage of the Internet may be getting a glimpse of what's to come in the near future," said Paul Engstrom, editor of Medicine on the Net. "It's the start of a revolution. The vast majority of those physicians who are on-line are using only the e-mail systems to communicate with their patients and other physicians. But there is so much more out there for medical professionals." ■

Edgar announces

(Continued from page 1)

since July. In mid-November, Rush agreed to extend its services and accept phone calls from Downstate hospital emergency departments. "They have been doing that without any additional funding, so at least the most serious cases would get a higher level of attention from the skilled toxicologists that Rush has available," explained Karen Hughes, MCHC vice president.

Downstate residents, however, have looked elsewhere to get the help they need. A St. Louis poison control center, for example, reported that its call volume from

Illinois tripled since July. "Right now, we're taking about 1,000 calls per month. Previously, we were taking [calls] somewhere in the low 300s," said Michael Thompson, a pharmacist and managing director of the Missouri Regional Poison Control Center at Cardinal Glennon Children's Hospital. The increased load will cost the center \$180,000 over the course of a year, he said.

For several months, MCHC has been seeking contributions from its member hospitals, the community and the state to keep the Rush center operational. "We do not have enough to operate throughout 1997," Hughes said. "But we're certainly well enough into our funding efforts to go at least six or nine months. And we're very hopeful that during that time we'll be able to raise enough funding for the entire year for the entire state." To function optimally, a statewide poison center requires almost \$2 million per year, according to MCHC. Including the \$250,000 from the state, MCHC has obtained about \$845,000 in contributions, according to MCHC.

The last time state funds were provided for poison control centers was in the 1994-95 fiscal year when a total of \$150,000 was provided to Swedish-American and Rush.

The Illinois College of Emergency Physicians formed a poison control funding task force after receiving calls from the college's Downstate members. They expressed concern about the volume of calls they received after Swedish-American closed and problems in treating the more complicated cases, said Ginny Kennedy Palys, executive director for ICEP. The task force's goals include securing short-term funding to ensure the center at Rush remains open and working on a long-term funding mechanism to keep a poison center financially stable.

To reach its goal, the task force enlisted the help of a cross section of organizations. Task force members include ISMS, MCHC, the Illinois Hospital and HealthSystems Association, the Illinois Association of HMOs and the Illinois State Chamber of Commerce. "All these groups, which sometimes don't agree on things, all do agree that this is an important public service," Palys said.

The ISMS Board of Trustees approved supporting state funding for a statewide poison control center in Illinois at its Nov. 9, 1996, board meeting.

Studies have shown that poison control centers, which are open 24 hours a day, every day of the year, save money by preventing emergency department visits, Hughes said. For every \$1 spent on a center, \$4 to \$9 are saved in medical expenses, she added. In 1995, Rush handled 72 percent of its calls without having to refer patients to the emergency department, MCHC said.

The center at Rush fields more than 50,000 calls annually, a number that doesn't include the overflow caused by the closure of Swedish-American's center, Dr. Leikin said. The personnel who staff the centers, including physicians, nurses and poison information specialists, have expertise in treating poisonings. "Because this is a specialty, those people who deal with the issues every day always keep up [on their field]," Hughes said. "Although there are some computer databases and other systems out there that give you information about pharmaceuticals and other products, they aren't always updated [to the extent that] people who work in the field are." ■

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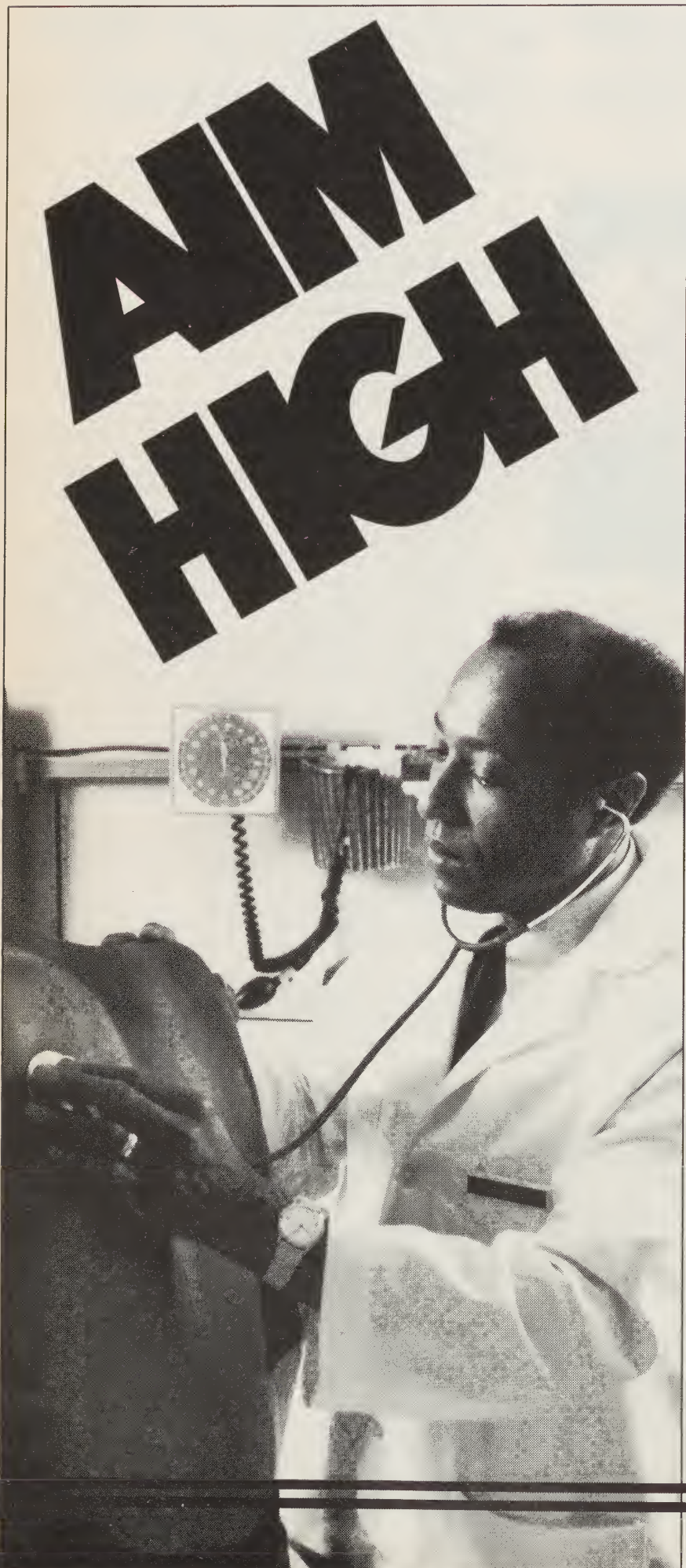
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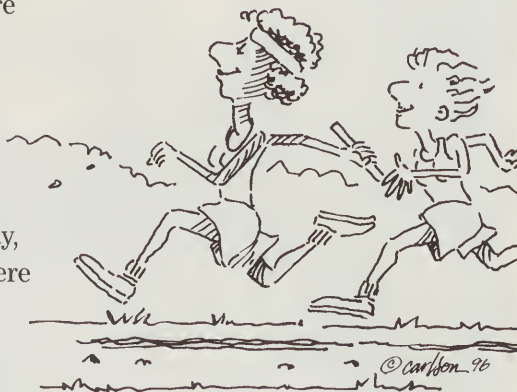
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Attorney general

(Continued from page 1)

liminary stage of the proceedings. Grounds cited by Macon County Judge Scott Diamond were violation of the right to privacy and violation of the separation of legislative and judicial powers.

ISMS submitted an amicus curiae brief to the Supreme Court last October. The brief states support for tort reform measures that were put in place to streamline "what the legislature perceived as a cumbersome and quixotic system of personal injury litigation." ISMS' brief also points out that every medical record that can be requested of plaintiffs as a result of tort reform could have been requested before: "It is not access to records that has changed but merely the timing and methodology by which these records may be sought."

It is not access to records that has changed but merely the timing and methodology by which these records may be sought.

The Illinois Civil Justice League, a coalition of groups including ISMS, also filed an amicus curiae brief in October.

Some plaintiff attorneys seem to be applying pressure by sending letters to physicians that describe what medical data doctors can discuss and release in pending medical malpractice lawsuits. One such letter tells a doctor that his patient authorized the release of medical records only because consent is required under the amendment and not voluntarily. It says the doctor is not "required" to communicate with defendant parties to the lawsuit but only "authorized" to do so, then implies that conducting communication "permitted but not required by law" may violate the Medical Practice Act.

"What these plaintiffs' attorneys seem to be trying to do is almost to have the best of both worlds," said Morse. "They seem to be trying to comply with the state law because they have no choice, but at the same time, they say to doctors, 'We'd rather you'd not honor this [authorization to release records].'"

The letters are correct in that physicians are authorized but not required to provide the medical information and talk with defendants, defense attorneys or another representative. "But that doesn't mean that physicians have to do it if they don't want to or don't think it's appropriate. There is some discretion for physicians to do what they think is best," Morse said. Physicians could wait until they receive a court subpoena.

The decision about whether to release information should be made on a case-by-case basis, since each case has different circumstances, Morse said. Before making a decision, physicians may want to discuss letters like those from the plaintiff attorneys with their lawyer. "[ISMS] policy is that a physician can rely on a consent [form] signed by a patient," Morse said. "Beyond that, it's up to individual physician judgment." ■

Judge in Best case

(Continued from page 1)

personal injury cases." The law also violates the sections of the constitution that give injured citizens the right to complete compensation, the judge wrote.

The judge also specifically invalidated sections of the law, including the \$500,000 cap on noneconomic damages, which he said violates the following sections of the state constitution: due process and equal protection, right to remedy and justice, trial by jury, separation of powers and special legislation. "There is no conceivable argument that can be made in

good faith to suggest that arbitrarily limiting damages complies with the constitutional rights enjoyed by the citizens of the state of Illinois," the judge wrote. "Such arbitrary limits fly in the face of each of the provisions above cited."

The Supreme Court last November rejected a petition by the Illinois Civil Justice League – a coalition of various groups including ISMS that joined together to support tort reform – to file an amicus curiae brief in support of the Best appeal. "We believe very strongly that there should be a full airing of all appropriate views," said Ed Murnane, president of the ICJL. "Since the

Supreme Court will undoubtedly treat both sides of the tort reform debate with an even hand, the decision not to allow our participation indicates that no public participation will be allowed. We believe that all sides should be heard."

The Illinois Association of Defense Trial Counsel also filed a petition seeking amicus status, and it, too, was rejected, according to a Supreme Court clerk.

Last November, Cook County Judge Kenneth Gillis issued final rulings on consolidated challenges to the tort reform statute, finding the entire statute unconstitutional, said Morse. The cases will now go to the Supreme Court. ■

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PAGE 7

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PAGE 2



John McNulty

PANELIST ISMS PRESIDENT-ELECT Jane Jackman, MD (second from left), chats with Accord Health Network CEO Burton Vanderlaan, MD, before the live WTTW telecast of a town meeting on managed care. Looking on are Illinois Rep. Carolyn Krause (R-Mt. Prospect) (left) and Illinois Association of HMOs President Barbara Hill (right). Illinois Medicine will cover the event in an upcoming issue.

States pass flurry of managed care bills

ROUNDUP: Legislators nationwide considered more than 1,000 measures last year. BY CHRIS PETRAKOS

[CHICAGO] In 1996, states across the nation acted on concerns about the quality of care that patients get under managed care. Nearly every state introduced managed care legislation, much of it based on proposals contained in the AMA's comprehensive 1994 Patient Protection Act, which is currently being "modified and restructured," according to an AMA spokesperson. In fact, more than 1,000 managed care bills were introduced in 1996, according to the Medical Group Management Association, an Englewood, Colo.-based organization for professionals in medical practice management.

The MGMA recently published the Summary of State Managed Care Laws, which describes state managed care laws enacted as of Aug. 1, 1996. Length-of-stay laws are the most common, with 27 states, including Illinois, having passed such legislation in 1996. Three states already had the law in place. The second-most-popular law deals with patient protection information and re-

quires managed care plans to provide enrollees with specific information regarding terms, conditions and exclusions. Other reforms that became law last year focused on any willing provider, patients' freedom of choice, point of service, due process for physicians, patient protection, physician and provider fairness, utilization review safeguards, gag rule restrictions, direct access and consumer protection.

In Illinois, the Managed Care Patient Rights Act, which was introduced in the spring 1996 legislative session, is being reviewed and fine-tuned. "It will be reintroduced in the Illinois General Assembly this spring," said ISMS President Sandra Olson, MD.

Calling the flurry of legislation "phenomenal," Laura Tobler, research analyst at the National Council of State Legislatures, said that as managed care penetrates more deeply into markets, state legislatures are becoming better educated about what to expect and what needs to be regulated. "There (Continued on page 8)

ISMIE earns upgraded 'BBB' rating from Standard & Poor's Corp.

UPGRADE: International rating agency praises approach to changes in medicine. BY JANE ZENTMYER

[CHICAGO] In January, the national rating agency Standard & Poor's Corp. upgraded ISMIE's rating, including its ability to pay claims, to an official "BBB." The rating was based on an in-depth analysis of ISMIE's financial information and interviews with company representatives. ISMIE was cited for its strong market position, solid capitalization and adequate loss reserves. S&P had previously given ISMIE a "BBq" rating, which is based solely on publicly available information filed with the Illinois Department of Insurance.

To determine ISMIE's rating, S&P's representatives reviewed five years-worth of financial data from such documents as balance sheets and statements of operations, according to an ISMIE representative. S&P also visited ISMIE's Chicago headquarters Nov. 12 to gather more firsthand information about the company's physician-first philosophy and internal operations.

"This rating further solidifies ISMIE's reputation as a strong, financially secure company that will be here for Illinois physicians for many, many years," said Harold Jensen, MD, chairman of the ISMIE Board of Governors. "Standard & Poor's, like others that have rated ISMIE, assigns this rating only to the companies that earn it." A "BBB" is considered a secure rating, comparable to the "B+" or "very good" rating assigned last November by the international insurance rating agency A.M. Best Co., he explained.

"ISMIE's unique ownership

as a reciprocal enables it to have a dramatically different approach to profitability than some of its commercial competitors," said a report released by the New York-based Standard & Poor's. "The company essentially returns all 'profits' to policyholders by either forgoing rate increases or offering claim-free discounts."

Dr. Jensen explained that ISMIE would have to show substantial profits to receive the highest Standard & Poor's rating. "That isn't our goal," he said. "ISMIE exists to serve its

(Continued on page 8)

Gov. Edgar signs revised Medical Practice Act

UPDATE: Patient records, license applications and mandatory reports are some of the issues covered. BY JANE ZENTMYER

[CHICAGO] On Jan. 17, Gov. Jim Edgar signed the revised Medical Practice Act - legislation that clarifies the 1986 act and governs how physicians are licensed and will practice medicine for the next 10 years. Illinois Medicine previously highlighted significant changes to the act, and the following covers more clarifications.

Among the new provisions is a requirement that physicians must establish and maintain patient records as required by law. "Most doctors already keep records, but there was never a provision in the [Medical Practice Act] that required them to," said Daniel Bluthardt, legislative liaison with the Illinois Department of Professional Regulation, which administers

the Medical Practice Act. The revised act, however, doesn't specify how long physicians should keep medical records.

Although Illinois does not have an across-the-board mandatory retention requirement, ISMS recommends that physicians follow the longest applicable statute of limitations for bringing professional liability lawsuits, according to the ISMS brochure "A Physician's Guide to Medical Record Access and Retention." Illinois law requires X-ray and roentgen photographs to be retained for five years unless the statute of limitations on damages exceeds the five-year time period - for example, in the case of minors. In addition, if litigation is pend-

(Continued on page 11)

INSIDE

Legislature
approves
Acupuncture
Practice Act



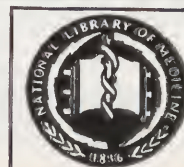
PAGE 3

DEPARTMENTS

News Briefs2
Commentary4
ISMIE Update6
Classifieds9

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ISMS, ISMIE help physicians renew their state medical licenses

Members get letters, phone calls and published articles as reminders. BY JANE ZENTMYER

Physicians know that every three years, they need to renew their medical licenses by the deadline so that the Illinois Department of Professional Regulation has enough processing time. Most also know that the consequences for nonrenewal can be stiff: disruption of practice, the loss of their medical malpractice coverage and even penalties from the Illinois Medical Disciplinary Board. Even knowing those facts, though, it's easy to procrastinate given the volume of paperwork doctors face every day. That's why ISMS and ISMIE worked hard last year to remind physicians of the need to renew by the state's deadline.

"We try to provide services for physicians for what is really an important matter," said M. LeRoy Sprang, MD, chairman of the ISMS Board of Trustees. "If you don't get your license renewed, you're practicing medicine without a license. If you're practicing medicine without a license, you're not covered by malpractice insurance."

Physicians should have received their

renewal forms in the mail in early June 1996. The completed forms and fees were due last July 31. A 90-day grace period, which ended in late October, gave physicians who missed the July deadline another chance to submit the paperwork.

"This year, we checked with the department and found which physicians had not yet submitted their applications and tried to notify [them]," Dr. Sprang said. "We repeatedly sent letters to remind them and followed up with telephone calls."

ISMS also shared the names of non-renewing physicians with county medical societies and offered help in contacting those members by telephone. In addition, Illinois Medicine published articles and notices about license renewal when the three-year renewal cycle began in June.

Among the nearly 32,000 physicians licensed to practice in Illinois, about 14 percent have out-of-state addresses, according to IDPR. Out of the total, only 3,832 physicians had not renewed

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Physicians can delete their names from mailing lists

ISMS does not sell or distribute membership mailing lists, with only rare exceptions made for public health alerts. Questions about ISMS' mailing list policy arose recently when some Illinois physicians received unsolicited mailings about the use of RU-486 from a Texas-based company called Life Dynamics Inc. The source of the mailing list used by the group is unclear.

The AMA will delete the names of Illinois members from its mailing list if individuals request it. But that means that those doctors would no longer get some of the free items and publications that are now mailed to them - for example, drug samples and the FDA Drug Bulletin, according to the AMA. But physicians deleted from the list would still receive AMA publications like JAMA and AM News. For more information, call (312) 464-5759. Written requests for deletion from the mailing list should be sent to the AMA Department of Data Collection, 515 N. State St., Chicago, IL 60610.

Marketing groups may get physicians' names and addresses from commercial sources. To remove your name from most mailing lists, send your name, address and request to the Direct Marketing Association, Mail Preference Service, P.O. Box 9008, Farmingdale, NY 11735-9008. Your mail should be reduced about 90 days after the group receives the information, according to the association.

their licenses by Aug. 31, and only 451 were ISMS members. By early November, only 230 ISMS members had failed to renew their licenses. Almost two-thirds of those nonrenewing ISMS members were retired.

ISMIE joined the renewal notification effort by calling and writing to policyholders to remind them that failing to renew their licenses could result in a gap in their insurance coverage or cancellation of their policies. "Insurance is predicated on valid medical licenses. Physicians who for whatever reasons forget or don't get their licenses back and continue to practice medicine will have trouble with their insurance coverage because they are in violation of the law," said Harold Jensen, MD, chairman of the ISMIE Board of Governors. "This is a very serious matter."

As a physician-owned company, ISMIE understood that license nonrenewal could disrupt medical practices and wanted to help physicians avoid unnecessary hassles, Dr. Jensen

explained. Several physicians said they thought their licenses had been renewed, but often a mechanical problem had held up the approval, Dr. Jensen said. For example, the applications may have been mailed to the wrong address.

After the disciplinary board penalized several residents for being improperly licensed nearly 10 years ago, ISMS developed an annual seminar for medical directors at residency programs to help keep them up-to-date on requirements in state medical licensing law.

ISMS will offer its Ninth Annual Residency Program Directors Seminar Feb. 14 at the Oak Brook Marriott Hotel. This year's program will include sessions on licensure changes in the Medical Practice Act, the effect of new immigration laws on licensure and problem areas in the 1996 temporary licensing process. The program fee is \$90 for members and \$110 for nonmembers. For more information or to register, call ISMS at (312) 782-1654 or (800) 782-ISMS, ext. 1146. ■

Third-year students to learn rural medicine ropes

[PEORIA] Six Downstate communities will receive an extra boost to their health care systems, thanks to a University of Illinois College of Medicine-Peoria preceptorship program, according to the university. Under the three-year, \$300,000 grant, the Rural Student Physician Program will place third-year medical students with family physicians who practice in rural communities.

ISMS' House of Delegates policy endorses the use of preceptorships and primary care residency rotations in areas where there's a shortage of primary care. The Society has also written to Illinois medical schools urging them to implement preceptorships and residency rotations.

Sponsors hope to expose these students to the experiences necessary to provide rural health care while providing some smaller communities with at least one extra physician. The RSPP will start with six students for three years, possibly expanding to 12 to 15 students and preceptors. The Federal Bureau of Health Professions provided the grant to the university's Department of Family and Community Medicine.

The program's principal investigator, John Halvorsen, MD, explained the goals

of the program: "Medical educators face several major challenges. We must prepare physicians with the skills to practice in a quickly changing health care environment; we must produce more physicians who can enter the generalist disciplines; and we must encourage more of them to enter practice in rural communities."

Right now, the 11 rural communities vying for the medical student program are Canton, Effingham, Flanagan, Galva/Kewanee, Geneseo, Gibson City, Granville, Litchfield, Macomb, Marseilles/Ottawa and Streator.

Students who demonstrate potential to return to rural practice must pass a screening process that looks at their independence, self-directed learning style and interest in community health. The selected students will be notified in March.

Program sponsors said students will spend their days during the 32-week clerkships accompanying the preceptors on hospital rounds, assisting in surgery and evaluating patients in clinics, hospitals, homes and nursing care centers. Work will also likely include after-hours surgeries and deliveries, serving on-call with their preceptors and work with emergency department patients. ■

General Assembly approves Acupuncture Practice Act

LEGISLATION: If measure is signed into law, acupuncturists must register with IDPR. BY JANE ZENTMYER

[SPRINGFIELD] Gov. Jim Edgar is now reviewing the state's first Acupuncture Practice Act, which will set up registration procedures and fees and create a disciplinary process for practitioners. Lawmakers sent the bill to the governor in early December.

"This bill allows physicians to take advantage of the acupuncture that they and their patients have been reading more about," said David Edelberg, MD, medical director of the American Holistic Center in Chicago. "The bill also works to build a bridge between conventional and alternative [medicine]."

He said he believes that under the bill, physicians' relationships with acupuncturists would be similar to those with physical therapists. Patients could ask their physicians for acupuncture as a treatment for chronic pain, for example, he said. Doctors could then give written referrals to their patients for a specific number of treatments with registered acupuncturists. The patients would report back to their physicians when the sessions were completed. "Acupuncturists have been asked to keep in touch with the referring doctors and let them know the treatment plan," he added.

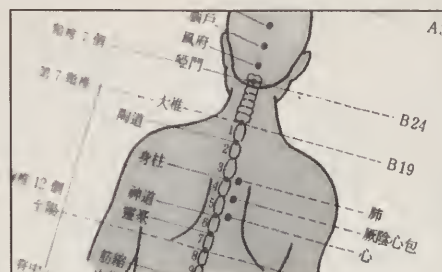
The bill reflects ISMS House of Delegates policy stating: "Acupuncture is a treatment modality for some conditions that should be available to patients when performed either by physicians licensed to practice medicine in all of its branches and dentists, or through physician referral by prescription to a licensed acupuncturist. Throughout the treatment plan, the physician must maintain control of the medical management of the patient."

"Several members came to us and expressed a desire to work with acupuncturists," said Joan Cummings, MD, chairman of the ISMS Council on Education and Health Workforce. "So we became involved with developing legislation so that those who wish to work with acupuncturists can." The council reviewed the definition of acupuncture and related literature, according to Dr. Edelberg, who worked with the council.

Under the bill, physicians licensed under the state Medical Practice Act and dentists will not need to register with the state to practice. But acupuncture practitioners who are not licensed must meet requirements set up by the measure and by the Illinois Department of Professional Regulation, which would administer

the act. Those qualifications would include passing the exam given by the National Commission for the Certification of Acupuncturists.

The bill defines acupuncture as "a method of stimulation of a certain point



John McNulty

or points on or immediately below the surface of the body by the insertion of pre-sterilized, single-use, disposable needles for the treatment of certain diseases or dysfunctions of the body." The act specifies that acupuncture does not

include, among other things, prescribing drugs, herbal preparations or nutritional supplements. "The MDs were specifically very uncomfortable with acupuncturists using Chinese herbs," Dr. Edelberg said.

Under the bill, acupuncturists could be disciplined if they misrepresented their credentials to become registered or treated patients in a way that was inconsistent with the definition of acupuncture or with written physician referrals. Only practitioners with valid registrations could advertise or represent themselves as acupuncturists. Depending on the offense, acupuncturists could face criminal penalties and revocation of their registration. ■



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- * Generally, only one EKG or x-ray interpretation per test will be paid. However, a second interpretation under unusual circumstances may be paid when documented by the provider.
- * One complete interpretation and report will be paid. "Reviews" of previous interpretations will not be paid. As stated in the Federal Register, "over reads" for quality control purposes are not covered.
- * When multiple claims are filed, the interpretation and report which directly contributed to the diagnosis and treatment of the patient will be paid. As stated above, physician specialty will not be used in making this decision.

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EDITORIAL

Reality and hyperbole

FDA proposes to force Seldane off the market." "Too much fruit juice for preschoolers may cause obesity and shortness." "Patients die after the failure of Ventritex device." "Rabies threat lurks." "Which comes first: depression or heart disease?" Who wouldn't be depressed with newspaper headlines like these? The headlines and their related stories ran in local and national papers in mid-January, and you have to wonder how many people stopped taking Seldane, petting dogs and drinking juice that day. With some media reports, it's hard to tell where reality ends and hyperbole begins.

Television reporter John Stossel recently came clean in the Wall Street Journal about how the media loves to hype scare stories – especially in science and medicine. He said his epiphany happened when a producer rushed into his office pitching a story on Bic lighters, which had exploded and killed people. Stossel said he found it hard to pursue the story after he found that more people are killed by beds and plastic bags than lighters.

Bernard Cohen at the University of Pittsburgh calculated the number of days subtracted from a life span by certain things, activities and conditions. The low risks were toxic waste sites like the Love Canal, pesticide residues, flying in airplanes and house fires, which cause a loss of only 0 to 18 days. But cumulatively, the low risks get more media cov-

erage than the following high risks: being 25 percent overweight (minus 303 days), smoking (minus 2,580 days) and living in poverty (minus 3,600 days).

Research is especially prone to distortion. As Stossel said, "In our love of scare stories, we in the media often find it effective to take a tiny and insignificant datum – or one sensational announcement – and run with it." And sometimes study reports are misunderstood and contribute to misconceptions.

A case in point is the largest U.S. study of death and dying, called "Support." The study was recently analyzed by a physician at the George Washington School of Medicine and reported in the Annals of Internal Medicine and the Chicago Tribune. The analysis showed that previous reports stemming from the study of terminally ill patients were false. Those reports had said that patients surveyed were pleading to die in peace but their doctors kept treating them. The researcher said that actually 90 percent of the dying patients in the study agreed with the care they received. There was no evidence of poor or inappropriate medical care, as had been reported.

The Wall Street Journal advised readers to keep in mind that in science, association is not necessarily causation; clusters often mean nothing; chemicals that harm animals don't necessarily harm humans; and science is highly politicized. We may not be able to end junk science, but we can keep it in perspective.

PRESIDENT'S LETTER

Going to pot

Sandra F. Olson, MD



We can settle this controversy by subjecting cannabis to the usual pathway of scientific study.

I have been intrigued by the recent debate over the legalization of marijuana for medicinal purposes. As I'm sure you are aware, the citizens of California and Arizona recently voted to permit doctors to legally prescribe marijuana in their states. California's initiative, Proposition 215, legalizes the use of marijuana for "any illness for which marijuana provides relief" and requires only a doctor's verbal recommendation. Arizona's Proposition 200 legalizes marijuana and other drugs, such as LSD and heroin, in cases where a doctor can cite a study supporting the medical benefit of the drug prescribed. Marijuana has been touted as a possible treatment for chemotherapy-induced nausea, glaucoma and AIDS-related illnesses.

Federal law prohibits the prescription of marijuana for any reason and conflicts with state laws that permit its use for medicinal and other purposes. Federal officials claim these state initiatives to legalize marijuana send confusing messages to teen-agers, since marijuana is the common "gateway" drug that begins the progression to other more addictive and serious drugs such as cocaine and heroin. These officials have warned doctors against prescribing marijuana, stating they will prosecute offenders on a case-by-case basis.

AMA President Daniel Johnson, MD, called for federal funding of research to determine the validity of marijuana as an effective medical treatment. Interestingly, the White House approved nearly \$1 million in late December to fund a comprehensive review of "clinical, medical and scientific evidence on the therapeutic use of marijuana." This research analysis is to be approved and performed by the National Academy of Sciences' Institute of Medicine. Health and Human Services Secretary Donna Shalala, PhD, emphasized that research support by the government must be peer reviewed, scientifically valid and designed to answer "questions physicians and patients are asking about the usefulness of smoked marijuana." This is a rea-

sonable approach, namely, asking for the usual evaluation of a drug and following standard procedures to determine its effectiveness.

The issue here seems to be separate from the law, voter opinion, emotional reactions and other considerations. At the heart of the matter is the potential benefit of a chemical compound called cannabis (tetrahydrocannabinol), which entered the world many years ago for both recreational and medicinal purposes. Since it is easily grown and widely available, its effects have become widespread and well-known. Hence, it has potential for easy access and abuse. But what has been stated as a true benefit to some patients with life-threatening problems has not emerged from accepted sources. I have been told by some oncologists that marijuana has no medical value at this time and that they have other drugs that are equally or more effective.

Morphine sulphate, a universally accepted and highly effective painkiller, also has significant potential for abuse. Was morphine ever studied using a rigorous, double-blind crossover technique? Or was its use recognized empirically, resulting in the drug's entree as a standard treatment in our pharmacopoeia?

We can settle this controversy by subjecting cannabis to the usual pathway of scientific study. In that way, the question of its medicinal value can be answered, and we can end this rancorous and emotionally charged debate with real knowledge rather than endless speculation.

If marijuana is a true wonder drug for a small, restricted and ravaged group of patients, is it fair to deny it to them? On the other hand, if other remedies afford the same professed benefits without the potential addiction and other negative effects, let's get that knowledge out to the doctors and the public so that patients can receive the treatment they need and deserve. Then everyone will benefit, and the message will be clear. Now, unfortunately, for some people, the message is only confusing.

GUEST EDITORIAL

Doctors get the short end of the health care reform deal

By Andy Rooney

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We all study and plan as if we knew how things were going to be later in our lives, but they hardly ever turn out that way. This must be more true for doctors than for the rest of us. In all the talk about health plans that will change the way we get our bodies taken care of, the most important people are the doctors, and they're getting the least consideration.

Doctors are what we need most. We don't need health plans. No one in all the history of medicine has ever been made well by a health plan. A health plan doesn't plan health, it plans money.

Established doctors could not possibly have anticipated how things were going to go when they applied to medical school many years ago. Had they known, they probably would have taken fewer courses in anatomy and more in the study of accounting and paperwork.

Young people in high school or college who wanted to be doctors studied the sciences that would help in medical school. They weren't thinking primarily of making a living; they were thinking of being doctors with all the good things that the word "doctor" implies.

It's somewhat true of what any one of us does, of course, that we can't foresee the changes that will take place in what we do for a living. It's also true that we accommodate what we do and how we do it to new developments in our business or profession. I wanted to be a writer before I ever heard of television. Doctors have had to change the way they practice as much as I've had to change the way I write. It hasn't been for the better in either case.

Everything in the world changes, and

there was no way the practice of medicine was going to be an exception, but it's too bad that the change made it more of a business and less of a profession. Doctors didn't mean it to happen. It was simply inevitable that something so important and involving so much money as our health does would end up in the hands of the money changers.

We all like to think of doctors as getting their satisfaction not from the money they make but from curing us of our ills. We understand their interest in making a comfortable living, but we don't expect them to have the same acquisitive nature that, for example, the insurance agent or real estate salesperson has. My naive admiration for doctors makes me believe still that most of them put medicine ahead of money.

A friend of mine, who does not feel the same about doctors, says surgeons wear masks in the operating room not as a sanitary measure but because they don't want the patient to remember what they look like when they get their bill.

It hasn't been so long since the doctor was part of the social structure of small-town America, not part of a corporation selling health. He was called "Doc." "Doc" charged what a patient could pay. The doctor's interest was in making people better, not acquiring wealth.

I like doctors. I like mine in particular, but I like doctors in general, too. I worry, though. A lot of doctors seem different to me than doctors used to be. I read about doctors forming corporations that buy up other group practices, or they buy the laboratory that does their tests and sell those services to other doctors. This seems as wrong to me as if I read of a banker or a real estate salesperson who was doing heart transplants.



Mom! Somebody took my flu virus experiment for biology.

Quotables

"For 14 years, everyone in this country has been conditioned to the idea that once you're infected with HIV, you're gonna die. The idea that these people will be able to stay with us and lead productive lives is really quite amazing. It's like a revolution."

— **Stella Fitzgibbons, MD**, AIDS specialist, on the drug "cocktails" that have helped some AIDS patients, *Newsweek*

"Our goal is to have as many win-win contractual relationships as we're able to."

— **Charles Francis**, senior vice president of business development at Advocate Health Care, on a deal with Humana Health Plans whereby Humana pays for joint consumer advertising for the organizations, *Crain's Chicago Business*

"Our concern is that they're trying to establish a zero-tolerance standard, where we can't make any mistakes. We think that's a very difficult standard to meet."

— **Jay Mahoney**, president of the National Hospice Organization in Arlington, Va., on the federal crack-down on hospices that seek Medicare payments for patients who aren't on the brink of death, *Wall Street Journal*

"The kinds of managed care we tend to see in these shows is the money-grubbing, bottom-line-obsessed version."

— **Arthur Caplan**, director of the Center for Bioethics at the University of Pennsylvania, on how popular television shows like "E.R." and "Chicago Hope" portray managed care, *New York Times*

"It's awful hard to hire nurses and doctors to work in a jail."

— **Frank Drew**, sheriff of Virginia Beach, Va., on the success of medical care delivered to prisons inmates by private companies, *Chicago Tribune*

Don't forget the ISMS House of Delegates Annual Meeting

The 1997 ISMS House of Delegates Annual Meeting will convene April 18-20. This year's meeting will again be held at the Oak Brook Hills Hotel, 3500 Midwest Road in Oak Brook.

The deadline for receipt of resolutions is the close of business March 18; a March 18 postmark is not sufficient. Resolutions received at ISMS offices after that date will be reviewed by the Committee on Rules and Order of Business to determine whether the house will consider them. Only delegates and voting members of the house may submit resolutions.

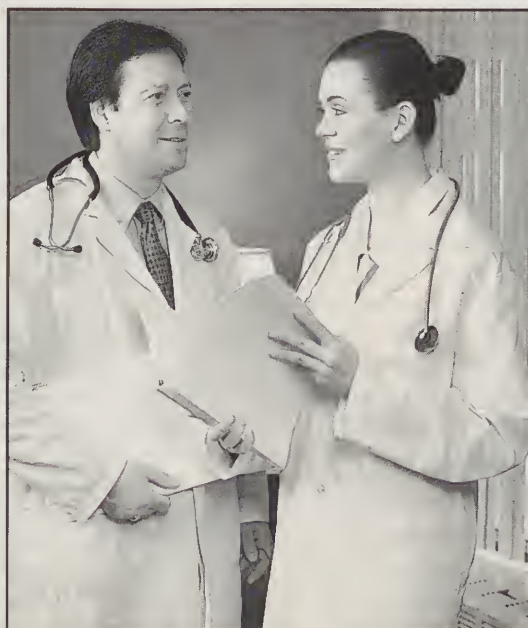
Resolutions should be addressed to Richard Ott, Illinois State Medical Society, 20 N. Michigan Ave., Suite 700, Chicago, IL 60602.

The ISMIE Annual Meeting is scheduled for April 16 and will also be held at the Oak Brook Hills Hotel.

Informational materials and meeting packets will soon be mailed to House of Delegates members. For more information, call (312) 782-1654 or (800) 782-ISMS.

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ISMIE Update

ISMIE coverage reflects changing face of medicine

New options add up to comprehensive liability protection.

BY DAVE WIETHOP

Last year was a very good year for ISMIE's policyholders. Not only did ISMIE add new options to its liability coverage, but its ranking from A.M. Best Co. was upgraded to a "B+."

ISMIE's comprehensive product line, called Seamless Coverage, offers protection to physicians for any risks that lie ahead. "The coverage reflects the changing face of medicine," said Harold Jensen, MD, chairman of the ISMIE Board of Governors. "Doctors are no

longer confined to their practices or to their hospitals, and neither are their risks. Now physicians are involved with HMOs and IPAs and supplemental medical care. This exposes them to risks they've not typically experienced before."

Today's ISMIE coverage can protect physicians from losses that stem from practicing in capitated systems, claims brought by employees and lawsuits against their groups or partnerships.

Last fall, the insurance rating agency A.M. Best Co. upgraded ISMIE's rating to a "B+" or "very good" and praised ISMIE for its lack of profit margin, as well as its "improved operating results, adequate loss reserves and strong position in the Illinois medical malpractice market." Best also commended ISMIE for its responses to the changing medical marketplace, particularly for offering physicians "one-stop shopping" for their liability needs.

Today, ISMIE insures about

9,500 Illinois physicians — more than any other insurer in the state. Since ISMIE was founded 21 years ago, it has watched competitors join the professional liability insurance market by offering deep discounts, often followed by years of significant rate increases. Some of these carriers eventually left the market.

From the start, Physician Professional Liability insurance has been the core of ISMIE's coverage, protecting physicians against medical malpractice lawsuits and claims. Reflecting the flexibility of the new ISMIE risk management coverage products, these policies can be written as broadly or as narrowly as physicians' practices warrant. Individual physicians, corporations and partnerships, physician clinics and any other legal physician entities are eligible for professional liability coverage. If the organization dissolves, tail coverage is available.

Physicians in groups of two or more doctors may consider the ISMIE Clinic Option, which offers premium savings of up to 40 percent. The discount recognizes group practices' effective peer review and risk management activities. Currently, 368 groups are taking advantage of this savings.

The ISMIE Clinic Option and Physician Professional Liability insurance can also address coverage for leaves of absence; nonphysician, part-time physician and locum tenens liability; and the needs of newly practicing and retired physicians.

ONE OF THE PRODUCTS introduced last year was ISMIE's Physician Stop-Loss policy, which protects physicians, groups and clinics working in capitated systems from catastrophic losses when patients require more care than the managed care entity will pay for. For physicians whose managed care contracts provide stop-loss protection, ISMIE coverage allows them to control the terms themselves.

ISMIE's Physician Business Practice Liability policy combines Errors and Omissions and Directors and Officers coverage. Physicians may be at risk for E&O liability through performing utilization review, cre-

dentialing, peer review or quality assurance activities in managed care. For example, a doctor might be responsible for determining whether a managed care plan should pay for a particular treatment such as a bone marrow transplant. If the decision is that the treatment shouldn't be covered, the physician could be sued by the patient, the managed care organization or both. Or physicians who credential doctors for HMOs could face a lawsuit if someone they credential allegedly harms a patient.

D&O insurance covers a company's managers and owners for liabilities incurred by the organization. If, for example, a managed care entity's board decides on a new business venture that stretches the entity's resources to the point of bankruptcy, the shareholders could sue the officers and directors for failure to protect corporate assets. Unlike D&O insurance written for businesses, the ISMIE policy defines quality assurance, peer review and utilization review and provides protection for those activities.

Physicians are often employers, and employers are increasingly at risk for suits alleging wrongful discharge, discrimination or sexual harassment. That was the rationale for the Illinois Employment Practices Liability policy — coverage developed by NAS Insurance Services Inc. and offered through ISMIE in conjunction with NAS. The policy offers protection limits up to \$1 million, including damages and defense costs.

To broaden the distribution of ISMIE products in the market, the company began working with professional brokers in 1996. The change allows ISMIE to address a different market segment — for example, group practice administrators and other nonphysicians who make purchasing decisions in managed care settings — and offers another option to policyholders.

While these policies have been introduced in the last year, ISMIE leaders stress that policyholders will continue to see the same high level of service that the carrier has been known for. "This is, and always has been, coverage for doctors led by doctors," Dr. Jensen said. ■

MALPRACTICE ROUNDUP

Court finds no cause of action for continuing care

The Ohio Supreme Court found that no cause of action exists in Ohio for the wrongful administration of life-prolonging medical treatment, according to the November 1996 issue of Medical Malpractice Law & Strategy.

In the case of Anderson vs. St. Francis-St. George Hospital Inc., a patient presented at the hospital with chest pains and told his physician that he wanted a "do not resuscitate" order. But the physician continued cardiac support. The patient then experienced tachycardia and stroke. Before he died, he brought an action against the hospital for failure to honor the DNR order, according to the newsletter.

The trial court granted summary judgment for the hospital, which the state Supreme Court upheld. The high court pointed out that "continued living" is not a compensatory injury.

Physician, pharmacist share liability in drug-related death

A Philadelphia jury found a physician 70 percent liable in the death of a patient who overdosed on the painkiller Darvocet, sharing the liability with the pharmacist who sold the drug, according to the Jan. 13 issue of the National Law Journal. The patient's estate was awarded \$3.75 million.

In Pawlowski vs. Chalal, the patient had taken Darvocet for eight years following an accident that injured her leg. She resumed taking the drug after injuring her hip a year later and subsequently overdosed and lapsed into a coma. The patient suffered from complications for several years before dying in 1994. Her daughter sued the physician, as well as the pharmacist and pharmacy that sold the Darvocet. The family's attorney charged that the physician and pharmacist should have been aware of the patient's dependency on the drug, thus contraindicating its prescription.

Judge acted properly in ordering chemotherapy

The Colorado Supreme Court ruled that a Denver judge acted properly in ordering medical treatment for a cancer patient despite her insurance company's refusal to cover the treatment, according to the December 1996 issue of Medical Malpractice Law & Strategy. The patient sought \$133,000 high-dosage chemotherapy treatment for advanced breast cancer, but the insurer said the dispute should be settled through arbitration.

A judge issued an injunction to begin the treatment, saying the patient could die without immediate chemotherapy. The state supreme court agreed with his action, adding that a judge may issue orders to maintain the status quo. In this case, the status quo was the patient's health.

Medicine is a family practice in Hopedale

A Downstate medical complex and its patients benefit from a local family's love of health care.

BY CHRIS PETRAKOS

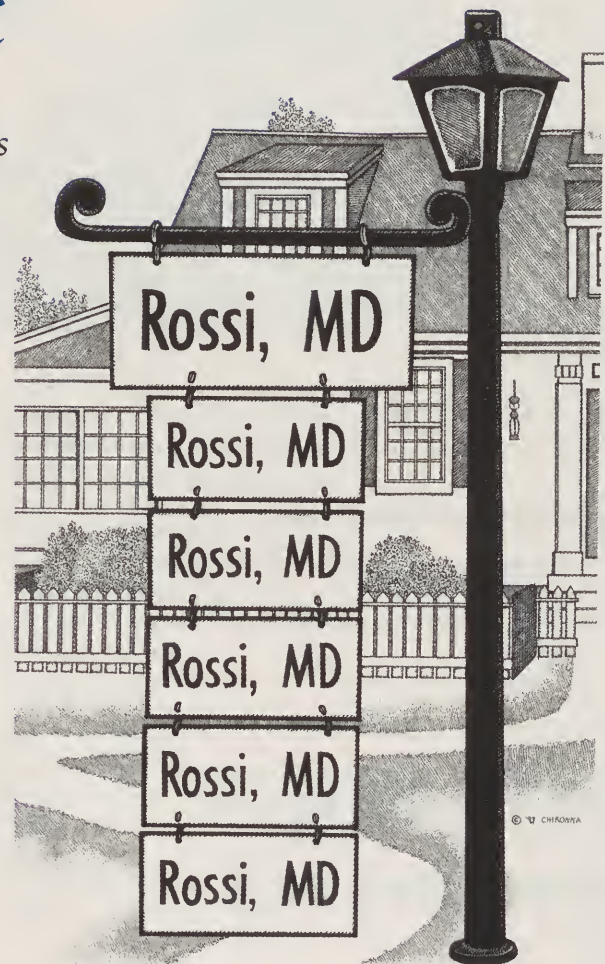
At first glance, Hopedale doesn't seem very different from other small towns that dot the farmland of central Illinois. With a population of 900, it might even be the sort of community used by analysts to illustrate the physician shortage in rural areas. But there's no shortage of doctors in Hopedale: Ten members of the same family, including six physicians, staff the Hopedale Medical Complex there.

It all started when Lawrence Rossi Sr., MD, an ISMS emeritus member, began practicing in Hopedale after the town's doctor died and the county medical society asked him to fill in. At the time, Dr. Rossi and his family lived in his hometown of Pekin, about 20 miles away. After six months of being on the road almost constantly, Dr. Rossi told community leaders in Hopedale that he couldn't stay any longer. That's when the people of the town went to work. The hospital, Dr. Rossi recalled, was established not only because of the community's need, but because of residents' willingness to help establish it. They bought bonds and notes in denominations ranging from \$100 to \$1,000, and they even volunteered their labor to construct the original hospital. The total cost was about \$150,000.

About every two years after the construction of the complex, Dr. Rossi expanded it, borrowing money on the hospital to build the nursing home and then borrowing money on the nursing home to build a retirement home. Dr. Rossi said there was a definite need, especially for the nursing home: "It was attached to the hospital because people who were ready to leave the hospital, but weren't able to go home, needed somewhere to go. Back then, a broken hip would keep [patients] in the hospital for 90 days. Today, if they're not out in three days, there is something wrong. Of course, we were charging only \$10 a day for room and board nursing care back then."

Today, the Hopedale Medical Complex serves 18,000 people in eight communities with a high-tech array of services. The medical facilities, which cover more than five acres and have a payroll approaching \$3 million, include a center for vascular disease, an alcohol and drug rehab center, a complete pharmacy, a skilled care nursing facility, an independent living center and residential apartments for retired people who may need medical assistance.

But what's especially noteworthy about the complex is that working there are nine of Dr. Rossi's 11 children and Dr. Rossi himself. That includes five sons –



Ronald Chiroma

Al, Phillip, Thomas, Lawrence Jr. and Matthew – who are all physicians and ISMS members, as well as daughters Lisa, who has a doctorate in pharmacy; Cynthia, who works in administration; Marietta, an RN; and Laura, a nurse anesthetist.

Why would so many children follow in their father's footsteps? "I don't have the slightest idea," Dr. Rossi senior said laughingly.

According to Matthew Rossi, MD, 1996 president of the Tazewell County Medical Society and a vascular surgeon who provides primary care, his father never pushed any member of the family into medicine. "I can't think of one instance ever where he suggested it to me. He was smart enough to know that he would never want to tell one of us to be a physician and then have us end up becoming one of these sorry saps who are unhappy with their work. There are plenty of doctors like that. But he knew that if you don't love to do it, you're in trouble."

Dr. Matthew Rossi has been practicing medicine at Hopedale since 1990, but his tenure really began when he washed dishes there at the age of 15. Because he worked at several large hospitals before returning to Hopedale, he had the chance to see several sides of medicine. He ultimately decided that he wanted the personalization that a small hospital allows.

"The big hospitals talk about quality and document it in so many ways, but what really matters is how the patients and their families are cared for during their stay and after they're released," he explained.

(Continued on page 8)

States pass

(Continued from page 1)

are very few states that have a patient protection act in the spirit of what the AMA intended, but there are now many states that have passed multiple bills with a wide range of reforms."

One of those states is California. In the past year, the California Medical Association supported a bill that establishes independent medical review for terminally ill patients who are denied experimental treatment by health plans. The association also set up a consumer grievance process. Before the new law, if patients had disputes with a health plan, they were required to use the plan's internal process for grievances, and if they were dissatisfied with the outcome, their only outlet was litigation. Now the state has a process to deal with patients' complaints, with an 800 number available to collect information from consumers.

Despite fierce and well-funded opposition from managed care entities, CMA was able to forge a coalition that included such unlikely allies as consumer and labor groups, nurses, chiropractors and psychologists, according to Danielle Walters, CMA's associate director of government relations. She said one of the turning points in getting legislators' attention was the association's publication of an HMO financial report that showed a dramatic difference between for-profit and not-for-profit organizations: "The report showed that as much as 30 percent of health care dollars were going into administration and profit. That really sent shock waves through the media. The legislature responded, and then the human stories began to come to

*As managed care
penetrates more deeply
into markets, state
legislatures are becoming
better educated about what
to expect and what needs
to be regulated.*

the forefront."

What remains to be seen is whether the uneven pattern of state regulation will eventually need some form of federal standardization. Tobler said that most state legislators think the state has a duty to regulate. "And they are taking that duty seriously. Some would feel that the federal government would interfere with the mission in their state and that they know their state best."

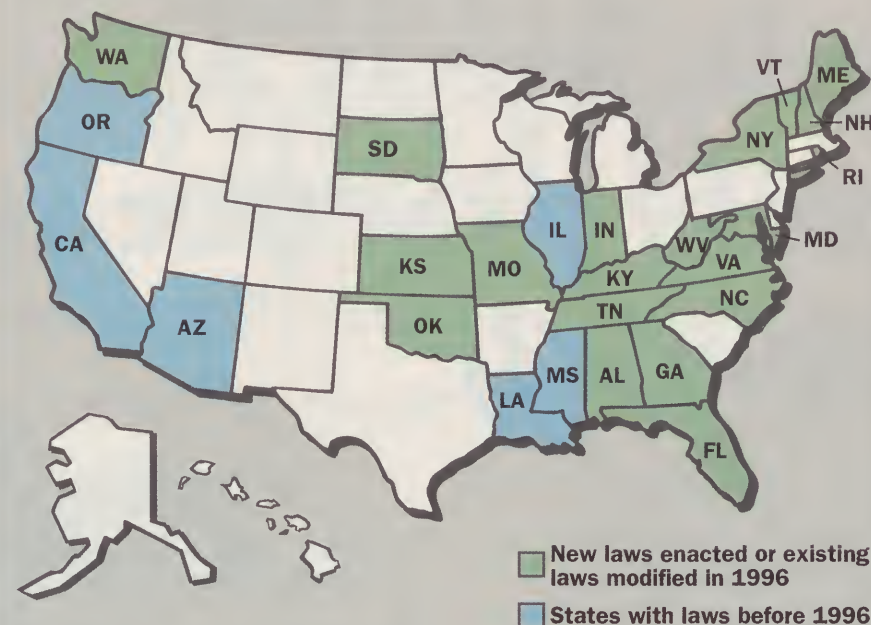
The federal government is already involved after passing a law last year that affected the length of hospital stay for mothers and babies. "That was an

issue that a lot of states had already moved on," Tobler added. "If we look at it historically, states have often taken the lead, with the federal government coming along later, as with the Kassebaum-Kennedy law that was passed last year and that addressed some of the issues that states had already worked on."

David Renner, director of legislation and public policy at the Minnesota Medical Association, said his state has recently used elements of the AMA's act as a platform for legislation. For example, state law prohibits financial incentives that would result in denials or cutbacks in patient care. Renner said that the relationship between the MMA and managed care companies is amicable, possibly because Minnesota requires all HMOs to be nonprofit. "Most of our members now are affiliated with HMOs in one way or another, and more and more of our members are employed by HMOs," Renner said. "So, we have to look at the law carefully."

■

States with patient protection information laws



ISMIE earns

(Continued from page 1)

policyholders with high-quality insurance products at a fair, yet realistic, price. We prefer to offer discounts and lower rates to physicians instead of inflating the bottom line for profit's sake or a higher rating. Large profits are not what this company is about."

S&P also pointed out that ISMIE's structure and new insurance products increase the company's ability to adapt to a changing marketplace. "ISMIE seeks to emphasize service through its network representatives, who also offer risk management support to all [insured] physicians," said the S&P report. "The local physicians who comprise ISMIE's Board of Governors help ensure that the company is sensitive to the changing needs of the health care industry."

The Illinois market became more competitive immediately before and after the enactment of tort reform, according to the report. The number of medical malpractice insurers has increased dramatically in recent years, but "ISMIE's strong brand name and recognition" have resulted in high policyholder retention rates, the report said. S&P attributed that retention in part to ISMIE's relationship with ISMS. "Affiliation with the Medical Society has given ISMIE a significant credibility advantage [over] some of the commercial carriers."

Another ISMIE strength outlined in the S&P report is physician ownership: "Standard & Poor's believes that ISMIE derives significant policyholder loyalty from its positioning as a physician-run, physician-owned carrier." ■

Medicine is a family

(Continued from page 7)

He said that doctors in larger hospitals seemed to have less input into how the medical facilities were operated and what was in patients' best interests. "I felt Hopedale offered me the best assurance that [quality patient care] would occur," he added.

Both Dr. Matthew Rossi and his brother Al Rossi, MD, a general surgeon who provides primary care, said they appreciate the opportunity to provide strong continuity of care and to work side by side. Their schedules are hectic: All the brothers work seven days a week and carry full caseloads, and they regularly participate in a Saturday morning radio talk show in which they report on developments in medicine.

Perhaps the siblings take their cues from their father. "If a person grows up in a family where the father is a hard-working primary care physician, you develop a very strong and positive attitude about what medicine should be about," said Dr. Al Rossi.

It's that attitude that keeps their father coming to work five and one-half days a week. The senior Dr. Rossi does some administrative work and spends time with patients. Although technology has transformed medicine in the 40 years that he's been practicing, the human element remains unchanged. He looks at it this way: "The basic ingredient of medicine – the doctor making the diagnosis and handling the patient – that hasn't changed, and I don't think it will change. It's a necessary part of healing. Out here, we're still doing it the old-fashioned way." ■

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Gov. Edgar signs

(Continued from page 1)

ing before the five-year mark, the film must be kept 12 years from the date it was produced or until notification of the conclusion of the case.

Another change clarifies when the statute of limitations begins to run for the Medical Disciplinary Board's action on a mandatory report. Mandatory reports are required under certain circumstances, such as when hospital privileges are curtailed or payments are made in malpractice actions. The clock now begins ticking at the board's receipt of the mandatory report. The board will still have one year to investigate and begin formal proceedings on the report if needed. Previously, the board often didn't get the reports soon enough to allow for an investigation, since some entities considered the one-year period to begin when the report was issued. "What this does is give us a year from the time we receive it, so that if we need to initiate a case, we then have time to investigate," Bluthardt said.

Under the revisions, permits for visiting physicians will remain valid 180 days instead of the former 120 days. The 60-day extension will give more time for overseas visiting physicians to complete training at Illinois medical institutions. "Periodically there have been problems with timing," said Joan Cummings, MD, chairman of the ISMS Council on Education and Health Workforce. "They get here, and they may have missed some time in the training. It is very hard to time the visa and the training and the airline schedule. These individuals routinely take this training back to their own country, and it was felt that really giving them the opportunity to finish [it] was important." The extension also coincides with the 180-day permits now available for visiting residents.

Under the new act, physicians who conduct a physical or mental exam of another physician at the request of the Medical Licensing Board, the Medical Disciplinary Board or IDPR are authorized to also testify before the board or department, Bluthardt said. An exam can be requested, for example, if a complaint has been received about a physician's physical or mental condition.

In a few instances, physicians who

had been examined cited physician-patient confidentiality, so the board couldn't find out the results of the exam, Bluthardt said. The new provision states that "no information shall be excluded by reason of any common law or statutory privilege relating to communications between the licensee or applicant and the examining physician."

The revisions also include as law the current policy of IDPR whereby physicians have a maximum of three years to complete the licensure process. Delays can be caused if applications are deficient in some way – for instance, if they were filled out incorrectly or a required

form wasn't submitted. Some applicants need to pass an exam before their licenses are approved, Bluthardt said.

Also spelled out is the fact that the Medical Licensing Board reviews the policies governing license approval but does not necessarily look at every application, Bluthardt said.

This modification mirrors IDPR's currently process for medical license applications. Qualified staff review the applications, and those submissions that don't meet the requirements are referred to the Medical Licensing Board for further review, according to IDPR spokesperson Tony Sanders.

As reported in a previous issue of Illinois Medicine, the revised act also requires 50 hours of continuing medical education per year as a condition of license renewal. The former version of the act required CME but didn't specify a number of hours. This change brings Illinois to the level of the 20 to 50 hours annually that most other states mandate.

Exactly how physicians can meet the 50-hour requirement will be worked out as IDPR develops rules to implement the act. The act states that IDPR will consider educational requirements for professional associations and specialty societies when deciding what qualifies as CME. ■

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PAGE 9

Illinois Medicine

ILLINOIS STATE MEDICAL SOCIETY • FEBRUARY 14 1997

**Physician
input can help
shape new law**

PAGE 6

Patient rights bill introduced into Illinois General Assembly

ADVOCACY: Measure contains guidelines to prevent compromises in the quality of patient health care. BY JANE ZENTMYER

[SPRINGFIELD] State Sen. Dan Cronin (R-Elmhurst) has heard from his constituents about managed care. After one man underwent major cardiac surgery in the hospital, his managed care plan not only insisted he be released within 24 hours, but also terminated the physician's contract during that time frame, Cronin said.

When the patient wanted a postsurgical consultation with his physician, he couldn't get it and faced problems with continuity of care, Cronin explained. "He could no longer talk to the doctor who had performed the surgical procedure, and he was directed to another doctor in the plan."

To help prevent such situations, ISMS refined the 1996 Managed Care Patient Rights Act and reintroduced it into the

Illinois General Assembly on Feb. 6. MCPRA is a comprehensive, bipartisan bill that sets guidelines to protect managed care patients from plan practices that could compromise the quality of patient care. Cronin is the bill's lead sponsor in the Senate.



Sen. Dan Cronin

"We have seen problems develop under managed care plans," said ISMS President Sandra Olson, MD. "Many managed care plans have been responsive and have indeed worked to correct these problems, but unfortunately not all have. As a result, doctors and patients are concerned about access to care and are frustrated and demanding some sort of relief."

The fact that legislators are responding to their constituents' concerns is apparent from the influx of bills addressing managed care. Last year, for example, legislators passed a bill requiring coverage for a 48-hour length of stay for mothers and newborns following a vaginal delivery and a 96-hour stay following a cesarean section. Legislators are now considering a bill to require a 96-hour length of stay for mastectomy patients.



Rep. Jeff Schoenberg

Some lawmakers think the fragmented approach has drawbacks, though. "I think one of the inherent risks of addressing

(Continued on page 14)



Ron Ackerman

AS GOV. JIM EDGAR (center) enters the Capitol prior to his State of the State address Jan. 22, he is flanked by Chicago Democrats Rep. Edgar Lopez (left) and Speaker of the House Michael Madigan.

Governor tackles health issues in State of the State address

INITIATIVES: Focus is access to women's health care, mental health services. BY JANE ZENTMYER

[SPRINGFIELD] The state will launch new public health initiatives including a program to improve awareness about women's health issues, announced Gov. Jim Edgar in his annual State of the State address on Jan. 22.

Illinois' first lady Brenda Edgar will spearhead the women's health initiative, which will be modeled after the Help Me Grow program. In three years, Help Me Grow has fielded almost 100,000 telephone calls from parents seeking advice about preventive services for children and families, Edgar said.

The women's health initiative will feature a public awareness campaign, maximize existing services and provide a toll-free telephone number for the public to access an array of information about women's health, Edgar explained. Primary funding will come from the private sector, he added.

"With the aging of the baby boom generation, millions of

women are facing midlife changes that have physical and psychological impact," Edgar said before a joint session of the Illinois General Assembly. "Women are more likely to be diagnosed with depression and face the misunderstanding associated with this real mental illness. It is time to recognize and do more about the health problems women face."

The governor also said the state expects to finish by July 1 the "most sweeping reorganization of state government since the early 1900s," the reduction of six cabinet-level agencies and the creation of the new Department of Human Services.

On Jan. 23, the governor appointed Howard A. Peters III to be the first secretary of the new department. Peters is the former head of the Illinois Department of Corrections and now serves as Edgar's deputy chief of staff.

The Department of Human Services is expected to save state

(Continued on page 15)

Court battles allow less leeway for managed care victories under ERISA

REGULATION: The tide may be turning for managed care exemptions. BY CHRIS PETRAKOS

[CHICAGO] When the Employee Retirement Income Security Act was passed by Congress in 1974, it was intended to provide uniform administration of companies' pension and benefit plans nationwide. At the time, it was to protect employees by making sure that pensions and other benefits could not be changed to make employees in one state better or worse off than employees in another state.

A significant aspect of ERISA is that it leaves to states the right to regulate the insurance industry. But that right is severely limited by what is known as the "deemer clause," which pre-empts self-funded ERISA plans from state insurance regulation. That exemption has opened the door for some managed care entities to argue in court that they cannot be held liable for malpractice

claims. The dispute arises over different interpretations of a small portion of ERISA that says that it will "supersede any and all state laws insofar as they may now or hereafter relate to any employee benefit plan described in this title."

The two words "related to" are the subject for much interpretation, with hundreds of court cases trying to determine what is – and is not – associated with the law. Until very recently, managed care entities have been largely successful in claiming exemption from state law based on ERISA.

A blow to the ERISA defense occurred in 1994 with the unanimous U.S. Supreme Court decision in *Travelers vs. Cuomo*. The Supreme Court ruled that state laws, which have only an indirect economic effect on an employee benefit plan, are

(Continued on page 15)

INSIDE

**Panel divided on
managed care**



PAGE 3

**Clinical trials
measure made
headway in
veto session**

PAGE 2

DEPARTMENTS

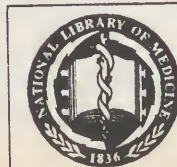
Commentary.....4

**IDPR
Disciplines10**

Obituaries11

Classifieds12

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Clinical trials measure made headway during 1996 veto session

RESEARCH: Measure passed Illinois House for first time.

BY JANE ZENTMYER

[SPRINGFIELD] About eight years ago, a Springfield oncologist treated a young woman after complications following a pregnancy. An ultrasound showed what looked like an ovarian cyst, but surgery revealed the problem to be pancreatic cancer, which eventually spread to her liver.

The oncologist, Edward Braud, MD, enrolled the patient in a clinical trial to determine if a particular drug could be used for pancreatic cancer, and after two treatment cycles, the spot on her liver disappeared.

This is a good example of the crucial role that clinical trials play in developing new cancer treatments, Dr. Braud, president of the Illinois Medical Oncology Society, told state representatives at a Health Care and Human Services Committee hearing in December during the veto session. But despite the importance of clinical trials, some insurers are denying coverage to cancer patients who participate in them. "What every patient asks me is, 'Dr. Braud, what's the best [treatment]?' " he said. "Well, in order for me to find out what the best is, I need to have clinical trials."

The hearing was part of a legislative debate on the merits of an ISMS-support-

ed bill that would have required insurers to cover patients who wanted to participate in clinical trials. The bill, which has existed for at least four years, advanced from the House committee and was approved by the House in December. Although the bill stalled in the Senate, it progressed further than it has before.

"We were thrilled when it got out of committee and really excited when it got out of the House," said Rep. Anne Zickus (R-Palos Heights), the bill's lead sponsor.

The measure was limited to cancer research to alleviate opposition, said Rep. Judy Erwin (D-Chicago), a co-sponsor who expects to reintroduce the measure in the spring 1997 session. "One of the [criticisms] was that if someone decided to test the efficacy of soup and nuts, they ought to be able to get [insurance coverage]," she said. Clinical trials that would qualify would include research approved by the U.S. Secretary of Health and Human Services and the National Institutes of Health, according to the bill.

Opponents also argued that the bill would increase costs to insurance carriers and businesses by mandating coverage of an extra service. But Erwin said the increase would be minimal because

Don't forget the ISMS House of Delegates Annual Meeting



The 1997 ISMS House of Delegates Annual Meeting will convene April 18-20. This year's meeting will again be held at the Oak Brook Hills Hotel, 3500 Midwest Road in Oak Brook.

The deadline for receipt of resolutions is the close of business March 18; a March 18 postmark is not sufficient. Resolutions received at ISMS offices after that date will be reviewed by the Committee on Rules and Order of Business to determine whether the house will consider them. Only delegates and voting members of the house may submit resolutions.

Resolutions should be addressed to Richard Ott, Illinois State Medical Society, 20 N. Michigan Ave., Suite 700, Chicago, IL 60602.

The ISMIE Annual Meeting is scheduled for April 16 and will also be held at the Oak Brook Hills Hotel.

Informational materials and meeting packets will soon be mailed to House of Delegates members. For more information, call (312) 782-1654 or (800) 782-ISMS.

the treatments given at clinical trials would replace the standard therapy typically covered by insurance companies.

Dr. Braud said that, historically, most insurance carriers paid for patient participation in the trials. But five years ago, a major Illinois insurance carrier included language in its contracts stating that patients who participate in clinical trials would be denied any and all insurance coverage for their cancer treatments, he said. "This had great implications for us," he noted.

Without clinical trials, new cancer treatments might not have been developed, Zickus said, citing statistics from the American Cancer Society. Fifty years

ago, only one in four cancer patients survived, but today, that number is almost 56 percent. Children with leukemia faced almost certain death 30 years ago; today, 75 percent of children with leukemia will survive, according to the ACS. New treatments also improve the quality of life for cancer patients, Zickus said.

"If you were to ask 25 oncologists, 'What happens to [a patient with] pancreatic cancer that has spread to the liver? How many of those patients survive one year?' the answer should be none," Dr. Braud said of his patient. "But [she] was on a research trial and got a drug that worked for her. Had she not been on the trial, she wouldn't be here today." ■

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Television panel divided on effectiveness of managed care

TOWN MEETING: Physicians, legislator and managed care representatives sound off. BY JANICE ROSENBERG

[MAYWOOD] When asked how they would rate managed care on a report card, ISMS President-elect Jane Jackman, MD, and Illinois Rep. Carolyn Krause (R-Mt. Prospect) gave grades of "C" and "C-," respectively, but President of the Illinois Association of HMOs Barbara Hill and Accord Health Network CEO Burton Vanderlaan, MD, said the industry deserves an "A-." The grading session occurred on the Jan. 9 live broadcast of "Chicago Tonight," a weekly television series airing on Chicago's PBS station, WTTW.

Host John Callaway said he hoped to raise questions and find answers about this increasingly powerful industry. "Almost faster than anyone expected, managed care has become the de facto health care policy of the United States," Callaway told the packed audience at the Cardinal Bernardin Cancer Center at Loyola University. "This takeover has happened without a single public referendum or congressional vote. By the year 2000, managed care will probably cover four out of every five Americans with health insurance."

DR. JACKMAN EXPLAINED her grade: "Too often [managed care] provides a pretty mean interference in doctor-patient relationships. And too often we have non-medical people making decisions about our patients' medical care. I don't think this is right. To get a referral to a specialist or to have a procedure done, I have to go through an 800 number. The people who answer have a 'cookbook,' and they tell me if it's approved or not. If the procedure is not approved, I don't think the patients will get it on their own - they can't afford it. So in essence, [the managed care plans] are practicing medicine."

Krause, who chaired the former House Health Care and Human Services Committee, said she supports legislation to regulate managed care in Illinois, adding that the issue will undoubtedly be a priority in this year's spring legislative session. Her preference is for one bill that would cover all aspects of health care, she said.

Explaining his high mark, Dr. Vanderlaan, the former medical director of HMO Illinois, said, "Patients are provided with insurance plans with comprehensive benefits and low out-of-pocket costs. This has been an incentive for people to get good health care. It's good for physicians because, in an era of account-

ability, we're focusing on outcomes, and that's the best way to deliver high-quality care in an efficient way."

When Callaway opened the discussion to members of the audience, comments expressed emotions ranging from
(Continued on page 8)

John McNulty



PANELISTS RELAX before answering questions posed by attendees of the Jan. 9 live broadcast of "Chicago Tonight." Participants include (from left) Illinois Rep. Carolyn Krause (R-Mt. Prospect); ISMS President-elect Jane Jackman, MD; Accord Health Network CEO Burton Vanderlaan, MD; and Illinois Association of HMOs President Barbara Hill.



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REPORT for Illinois Physicians

TERMINAL CARE AND SYMPTOM PALLIATION

Patients entering the terminal stages of a chronic illness, such as cancer, have unique physical, social, emotional and spiritual needs. Providers involved in the care of these patients play a very important role in assuring that appropriate measures are taken to help meet such needs. The goal is to obtain optimal symptom palliation in the environment most preferred by the patient, and in a manner consistent with the appropriate use of resources.

Major clinical needs of chronically ill patients include pain control and nutrition status. With respect to pain, the vast majority of patients can be effectively controlled without the need for hospitalization, by following well-established approaches to pain management.¹ The cornerstone of such care involves the effective use of analgesic and adjuvant drugs, which are available in many graduated strengths and routes (oral, oral sustained release, liquid, sublingual, transdermal or suppository). If adequate relief cannot be obtained with drugs administered by these routes, patient directed parenteral analgesia can be arranged - again rarely requiring hospitalization. In the exceptional case, when hospital admission for intractable pain is necessary, appropriate changes in the therapeutic regimen should be promptly instituted and designed with effective relief of pain and early discharge to the home environment as the goal. In general, a hospital stay of three days or less should be achieved.

The issue of nutrition is important for the terminally ill patient. It must be remembered that overall needs in this regard are variable and require individual tailoring with the goal being a tolerable level of feeding controlled by the patient or family. In terminally ill patients, forced feeding, tube feeding and parenteral nutrition can be dangerous, and should be avoided whenever possible.²

Other important problems that present patient care challenges for terminally ill patients, such as dyspnea, depression, anxiety and altered mental status, are discussed in a recent symposium.³

Despite the difficulties in keeping terminally ill patients at home, most patients do prefer to die in that setting.⁴ Hospice programs are an effective way to achieve this goal, as well as to facilitate a multi-disciplinary, caring-based approach to terminal illness. While most physicians are well aware of the concept of hospice care and the availability of local programs, it is important to emphasize referral of patients early enough in their terminal course to allow for the best outcome.

Patient and family satisfaction with hospice programs and the quality of life they afford is high. Although these programs are aimed at servicing individuals with a life expectancy of six months or less, the median survival for hospice patients is generally about two months. This suggests an opportunity for earlier consideration of hospice referral for appropriate patients. In addition, physicians can be pivotal in facilitating such care by recognizing the need to address the issue of advance directives early on in the course of such patients' illnesses.

¹Management of Cancer Pain" US Dept. Health and Human Services, AHCPR Pub. #94-0592 Rockville, MD March 1994

²Storey, P. "Symptom Control in Advanced Cancer" *Semin. In Oncol* 21:748-753 1994

³*Seminars in Oncology* vol., 21, no. 6, December 1994

⁴Thorpe, G "Enabling More Dying People to Remain at Home" *Br. Med. J* 307:915 1993

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EDITORIAL

A sobering issue

Physicians may be a little confused about a law that went into effect Jan. 1. It states that physicians and other health care workers are exempted from liability and professional discipline for informing law enforcement officials about the blood and urine test results of emergency department patients who've been injured in motor vehicle crashes. The legislation also says that in this situation, the confidentiality provisions of other laws pertaining to medical records and medical treatment don't apply. Physicians who still have concerns about confidentiality, however, may make their own decisions, since reporting the results of blood and urine tests is voluntary, not mandatory.

ISMS supported the new law, which is consistent with a resolution adopted at ISMS' 1996 House of Delegates Annual Meeting.

The rationale behind the law is that many of the alcohol- or drug-impaired drivers who are brought to an emergency department after a motor vehicle crash never face charges – or get help – for driving under the influence, according to the office of Illinois Secretary of State George Ryan. The statistics indicate a problem, though. A Northwestern University study of 625 drivers who received emergency treatment for crash injuries showed that 32 percent were legally drunk, 23 percent had a positive drug screening, and 10 percent had both alcohol and drugs in their system. In 1995,

581 people died in alcohol-related crashes – almost 43 percent of the 1,586 fatalities in motor vehicle crashes, according to the secretary of state.

An assistant to the secretary of state summarized the purpose of the law: "The goal is to make our highways safer and to have a means of providing or mandating alcohol treatment for these people." By reporting impaired drivers to police, physicians will help those drivers get the treatment they need to prevent future injuries. "We're not trying to get them convicted; we're just trying to get them help," said Ron Lee, MD, director of the emergency department at the Loyola University Medical Center in Maywood.

To gather information that will help implement the new law and evaluate its effectiveness, a pilot program has been launched at three hospitals – Loyola University Medical Center, Northern Illinois Medical Center in McHenry and Mt. Sinai Hospital in Chicago, according to Dr. Lee. The program will aim to clarify ambiguities. For example, some hospitals treat crash victims from several local law enforcement jurisdictions, so emergency workers may have trouble figuring out who should get test results.

A brochure about the new law is available to physicians. To get a copy, call (312) 814-2599 or write to the secretary of state's office at 100 W. Randolph Street, Suite 5-400, Chicago, IL 60601.

PRESIDENT'S LETTER

Back to the future – of Medicare

Sandra F. Olson, MD



Now that President Clinton no longer has to attack the GOP for proposed Medicare changes, he has proposed his own cuts.

Medicare is back in the spotlight. Both Republicans and Democrats are posturing with proposals to save the hospital trust fund that the elderly and disabled count on for their care. Current projections place this fund as bankrupt in 2001. Payroll taxes are the main source of the trust fund's income. Last year's rise in expenditures was accounted for by a surprising and unexplained increase in hospital admissions, while payroll taxes were not able to keep up proportionately.

Now that the election is over and President Clinton no longer has to attack the Republicans for their proposed Medicare changes, he has proposed his own cuts. On Tuesday, Jan. 21, the day after his inauguration, he laid out a proposed \$138 billion, six-year cost-cutting program. This is \$22 million more than last year. Previously, the GOP had scaled its proposed savings to \$158 billion. That was down from the \$270 billion it proffered last year, which President Clinton vetoed on the basis that Republicans were financing a 15 percent across-the-board tax cut. Republicans countered that their plan actually restrained the growth of Medicare. Mr. Clinton also recently proposed a "shell game" in which \$55 billion in home health care costs is shifted from the Medicare trust fund to the general revenue fund – what a guy!

What are the main sources of the cuts in President Clinton's proposal?

- \$45 billion from hospital payments
- \$46 billion from managed care reimbursements
- \$10 billion from physician payments
- \$9 billion from skilled nursing care
- \$9 million from reducing fraud and abuse

All in all, the proposed Medicare changes are price controls on providers of care. There is no discussion, at least at present, about

decreasing Medicare payments for those who are able to pay.

This plan obviously puts Medicare negotiations right on the table early in President Clinton's second term, underscoring the importance of balancing Medicare costs simultaneously with the budget.

For years, the AMA has been suggesting a plan to save Medicare. Its present proposal shifts Medicare away from government control and emphasizes choice. The plan is built on six steps:

1. Enhance choice, called "Medi-choice," using a defined contribution. Enrollees can use traditional Medicare or purchase private health insurance with a subsidy.
2. Encompass "Medigap" benefits and consolidate cost-sharing requirements into one single deductible.
3. Eliminate all price controls and let the market decide.
4. Develop an all-payer fund for graduate medical education, thus distributing this obligation more evenly and fairly.
5. Work to eliminate fraud and abuse, which are estimated to account for 10 percent of Medicare expenditures. Lower professional liability costs by adopting limits on noneconomic damages and attorney fees. Give physicians opportunities to establish cost-effective organizations such as PPOs, PSNs and PSOs.
6. Gradually increase the eligibility age to 67 years and reduce the subsidy for high-income benefactors and permit widespread use of medical savings accounts.

Those of us who will be approaching the age of Medicare eligibility over the next five to 10 years and who have dependents contributing to this system are vitally interested in making sure that Medicare is restructured fairly so the benefits will be there for those who will need them and for those who are bearing the costs.

Somebody, please do something now!

GUEST EDITORIAL

Tort reform not designed to make anyone wealthy

By Edward D. Murnane

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Is anyone really surprised that a trial lawyer has filed a \$25.5 million lawsuit against Mattel Inc. because a Cabbage Patch Kids Snacktime doll took a bite out of a 9-year-old girl's hair?

And no, it was not the same trial lawyer who tried, and almost got, several million dollars for the woman who spilled a cup of hot McDonald's coffee in her lap a few years ago.

Certainly, it seems as if Mattel, the manufacturer of the doll, has exercised some questionable consumer protection practices. And the toy manufacturer is likely to lose a fair amount of money because of those practices. The dolls are being pulled off the market, and Mattel is refunding \$40 to each purchaser of the doll. To date, there have been fewer than 50 reported hair-chewing complaints, but thousands of the dolls were sold in the pre-Christmas buying season.

What the current suit in California really demonstrates, once again, is the greed of the personal injury trial lawyers who – under the guise of consumer protection – will follow the scent of big money wherever it may lead.

Twenty-five million dollars for what? To compensate the young girl who may have some medical costs and who may have been shaken by the experience? Twenty-five million dollars' worth of shaking?

To deter Mattel from allowing the same thing to happen again? They've already pulled the product off the market. To punish Mattel? The marketplace will do that.

Or is the ultimate goal of the suit to put more than \$8 million (one-third of the hoped-for award) in the lawyer's pocket?

Fortunately, in Illinois, the law enacted by our General Assembly in 1995 would prevent the kind of ridiculous award being sought in California. But the new Illinois law also would provide full compensation for any injured parties, while at the same time, handsomely rewarding the attorney.

Let's see how this case would be resolved under new Illinois law. Although it seems a stretch, assume the young girl had \$10,000 in medical costs because of the damage to her hair and scalp.

Illinois law would require the defendant (Mattel, apparently) to compensate that amount in full (assuming the courts found Mattel responsible).

And Illinois law also would allow up to \$500,000 in noneconomic loss – to compensate for the pain and suffering the child may have endured during the incident.

And if the responsible party was found to have acted with an evil motive, i.e., to have known there were dangers and manufactured the product anyway, Illinois law would allow punitive damages to be assessed at three times the economic damages, or \$30,000.

So under Illinois law, as outlandish as it may seem, the victim of this hypothetical assault would be paid \$540,000 by the manufacturer. Plus another \$40 for the recall of the doll. The trial lawyer would make \$160,000 or more on the case.

Before the new Illinois law took effect, a case like the current California Cabbage Patch case would result in win-

nings of \$8 million or more for the lawyer.

That's why the trial lawyers have been fighting so hard to overturn the new Illinois law. In fact, Illinois trial lawyers have been fighting the new law since it was signed by Gov. Edgar in 1995. The first suit challenging the law's constitutionality was filed only 30 minutes after the governor signed it. Although that suit was thrown out, the trial lawyers have succeeded in finding judges who have ruled various sections of the new law "unconstitutional," and a review of the entire law is now working its way to the Illinois Supreme Court. (It should be noted that while some judges have found the new law "unconstitutional," other judges have found the same provisions to be "constitutional.")

The kind of suit filed in California, the equally ridiculous McDonald's hot coffee case, and many others like them are among the reasons elected officials in Illinois and in more than 40 other states have been working to change tort liability laws during the past few years.

Everyone agrees that an injured person should be totally compensated for his or her loss, and everyone sees that the responsible party – an individual, a corporation, a unit of government or someone in professional practice – should be held accountable for negligence or other wrongdoing.

But the system (it derives from English common law) was not established to make people rich, including the personal injury lawyers.

And there is clear evidence in most states, including Illinois, that the tort liability system before recent reforms was adversely affecting most citizens. A 1995 Northern Illinois University study found that the tort liability system in Illinois was costing every resident of the state in excess of \$1,000 per year.

Consider the recent case involving the village of Hanover Park in northwest Cook County. An unlicensed motorcycle driver who had been drinking lost control of the motorcycle and suffered paralyzing injuries. This happened before the new Illinois law, and the award of \$7.5



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million means the taxpayers of Hanover Park will be paying higher taxes for the next dozen years.

If the new Illinois law had been in effect at the time of the incident, the injured motorcyclist would still have recovered all of his medical and rehabilitation expenses, but the total assessment against Hanover Park taxpayers would have been no more than \$1.8 million.

The Hanover Park case, by the way, points out the need for even further reform. Local governments should not be viewed as "deep pockets" simply because there are taxpayer dollars to pay for jury awards. Large government agencies, such as the City of Chicago, the Regional Transportation Authority and the Chicago Transit Authority, are big targets.

Since the 1995 Illinois tort reforms were enacted, there has been a decline in the number of lawsuits; the business climate in Illinois has improved; and some insurance carriers have begun to stabilize and even lower some insurance rates.

All this has happened in the face of uncertainty over the trial lawyer challenges to the new law. Think of how much better the Illinois economy would be for all residents of our state without the trial lawyers' costly, self-serving challenges to some long-overdue legislation.

Murnane is president of the Illinois Civil Justice League.

LETTERS

A Donne deal

I almost hesitate to correct your error in attributing the quotation "No man is an island" to Thomas Merton rather than to John Donne in the "President's Letter" (Nov. 22 issue). Your mistake is of minor significance when measured against your splendid editorial that so eloquently reminds us of the real origin and meaning of Thanksgiving and its application to our lives today.

— Reynold J. Gottlieb, MD
Oak Brook

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Physician input can help shape new law

ISMS resolutions start a process that may end in legislation.

BY JANE ZENTMYER

After reading about ultimate fighting last year, a physician contacted DuPage County Medical Society delegate P.J. Floros, MD, to develop a resolution asking ISMS to seek a statewide legislative ban on the events. The House of Delegates ultimately approved the resolution with no changes. A bill banning ultimate fighting was introduced in the Illinois General Assembly, which eventu-

ally passed the measure. In July 1996, Gov. Jim Edgar signed it into law.

Ultimate fighting pits two contestants against each other – without protective gear – with only two restrictions: no eye gouging and no biting, according to the 1996 resolution. The contestants risk such serious injuries as paralysis and cerebral hemorrhage.

Dr. Floros explained how resolutions

begin at the county medical society level: "We have meetings at the DuPage County Medical Society, and we bring up different problems concerning physicians. We discuss and we formulate the resolution, and then we discuss it again. Then we decide if it's proper to go [forward] or if it duplicates previous resolutions." Many physicians become active in the political process by thinking of solutions to particular problems or medical concerns and crafting their solutions into resolutions that are

introduced at the ISMS House of Delegates Annual Meeting, said Richard Schmidt, MD, speaker of the ISMS House of Delegates.

Only delegates or voting members of the house can submit resolutions to the ISMS House of Delegates, but members can approach their delegates or county medical society to suggest one. For help

in developing resolutions, delegates may consult "A Guide to Developing Resolutions for Introduction to the ISMS House of Delegates," which is included in the packets sent before the Annual Meeting. Resolutions for the 1997 Annual Meeting are due March 18.

After introduction, resolutions are assigned to reference committees, where members can debate the pros and cons and recommend specific actions to the House of Delegates, Dr. Schmidt said. If a reference committee recommends changes, the house can accept or reject them or substitute new language. Of course, the house can also accept a resolution as it's submitted.

Like the proposal on ultimate fighting, many resolutions suggest legislative solutions. Regardless of the action recommended in the resolution, the Board of Trustees and ISMS' councils and committees and staff follow the HOD's directives, said Raymond Hoffmann, MD, former speaker of the House of Delegates and past ISMS president. If resolutions call for legislative action, the Governmental Affairs Council gets involved.

"The Governmental Affairs Council is in charge of reviewing the legislative proposals that originate from resolutions that have been approved by the House of Delegates and that specifically request a legislative approach," said Nestor Ramirez, MD, chairman of the Governmental Affairs Council. Council members put the legislative proposals through a "trial by fire" by discussing the pros and cons, he said. The council is a good forum for discussion, he added, because members represent all areas of the state. Bills of primary interest to ISMS are prioritized for the upcoming legislative session.

In addition to influencing state issues, ISMS resolutions might even affect issues nationally or in other states. "Many resolutions are introduced into the house instructing our Illinois delegations to take the issue to the AMA level," Dr. Schmidt said.

Dr. Schmidt introduced one such resolution, which called for strengthening physician participation on hospital governing boards so that physicians have the right, responsibility and obligation to hold a seat on the hospital board. The resolution was eventually adopted by the ISMS and the AMA. It also served as a model for Wyoming to change a law prohibiting physician participation on hospital boards, he said. "Here is an example of a local problem in one state that ultimately ends up as the solution of a more serious problem in another state."

The process in the House of Delegates is "democracy in action," Dr. Hoffmann said. "The freedom we have to have an idea made into law is perhaps one of our least understood freedoms but one of the more important ones. If we really believe in something and we can convince others of it, we have a chance to make it the law of the land."

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ISMIE Update

*Coming soon:
How office staff
use information
from risk
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seminars*

Policies and procedures aid risk management

Physicians should use written guidelines, review them annually and keep them up-to-date.

BY JANE ZENTMYER

How does your practice handle walk-ins? How do you deal with patients who don't get tests as ordered? What do you do when lab results aren't back as scheduled? These common occurrences don't have to become problems if you develop and follow a written policies and procedures handbook.

"Whether it's setting up an appointment or responding to a patient's complaint, there's got to be a system in place to oversee the operation and prevent patient neglect," said Boyd McCracken Sr., MD, a member of the ISMIE Board of Governors and former chairman of the Illinois Medical Disciplinary Board. "I think that a smooth-functioning office accrues to the benefit of the patient and the doctor. Satisfied patients are less likely to become embroiled in medical-legal actions."

Since practices vary, physicians should tailor their office policies and procedures to fit their needs, said Richard Sperling, MD, a member of ISMIE's Board of Governors and Risk Management Committee. Unlike some specialists, for example, family physicians and pediatricians tend to have more walk-in patients and need a plan of action to deal with them.

IN DEVELOPING POLICIES and procedures, physicians should involve their entire teams so that everyone understands what to do. It's also a good way to examine precisely how — and why — practices have handled situations in certain ways. For example, if a practice has a policy to always call patients immediately after receiving mammogram results, the reports are less likely to be misfiled or not communicated, Dr. McCracken said. An office that tells a patient that if she doesn't hear from the physician she should assume everything is normal simply "permits too many errors and allows too many things to fall

through the cracks," he said.

"Analyze the problem," Dr. McCracken advised, "and determine what would be the best way to handle it. Perhaps assigning a specific nurse or aide to be responsible for bringing it to the doctor's attention and have a system where the doctor must initial and check off every report."

The practice can run smoothly only if team members work together and know precisely what roles they play, he added.

Physicians and their staff should review policies and procedures at least annually and should address such key issues as documentation, Dr. Sperling said. If changes are necessary, make them. "Your office records may look the same now as they did 30 years ago, but there's so much more importance placed on documentation now. Too frequently, notes are very skimpy. If you're ordering lab work, why are you ordering that lab work?"

Risk management policies and procedures are covered in the ISMIE seminar "Risk Management: An Essential Office Practice," which focuses on all participants in a practice — physicians, office managers, nurses, receptionists and business managers.

When the policies have been reviewed, physicians should note the year at the bottom of the page to show that the rules were re-examined and updated, advised David Drake, a partner with the Springfield-based law firm Drake, Narup & Mead. Then the office staff should be sure to follow them. "If doctors or clinics are going to have rules and procedures for running their offices, they have to follow them. If they have them and then ignore them [and are named in a lawsuit], the first thing a plaintiff's counsel will do is bring that out," Drake said.

The policies need to be flexible enough to accommodate special situations and to allow for staff to do more than the

MALPRACTICE ROUNDUP

Hospital, surgeon found negligent over treatment of ankle

A woman who told caregivers her cast was too tight won a \$1.2 million verdict in *Pakech vs. Children's Hospital of Philadelphia*, according to the December 1996 edition of *Medical Malpractice Alert*.

After spraining an ankle in a car accident, the woman saw an osteopath for 10 months. A little more than a year later, she saw a surgeon, who diagnosed the problem as an unstable right ankle. The surgeon recommended "conservative treatment," which was unsuccessful, so he subsequently performed reconstructive surgery. The patient said that while she was in the hospital, she had complained of her cast being too tight.

The day after surgery, the patient was discharged by a resident but wasn't seen by the treating surgeon. That night, she presented at the emergency department complaining of severe pain. It was determined that the cast was too tight and that she was experiencing compartment syndrome in the lateral compartment of her right leg.

The woman sued the surgeon claiming that the syndrome caused permanent damage to the superficial peroneal nerve, resulting in permanent foot drop. She also sued the hospital for discharging her prematurely.

The surgeon and the hospital maintained that the compartment syndrome developed after the patient's discharge. Hospital records indicated that the woman had "very little pain" at discharge.

The jury found the hospital to be 99 percent negligent and the surgeon 1 percent negligent.

Jury awards \$13.62 million in premature birth

An upstate New York jury ordered an Ob/Gyn and a hospital to pay \$13.62 million to the family of a boy born prematurely with spastic diplegia, a form of cerebral palsy, according to the Dec. 16, 1996, edition of the *National Law Review*.

In *Karney vs. Arnot Ogden Memorial Hospital*, a woman visited her Ob/Gyn and complained of spotting and cramps in her 28th week of pregnancy. She was diagnosed with a urinary tract infection and given an antibiotic but was not examined. After the problem persisted, the woman was admitted to the hospital but was not examined. She began labor and after four hours, her Ob/Gyn ordered medication to stop the labor. But the baby was born a few minutes later. The boy was born with the condition because the birth was premature, the plaintiff attorney claimed.

The jury found the physician 70 percent liable for the premature birth and the hospital 30 percent liable.

Physician-patient privilege doesn't apply to open records

Once medical records are disclosed, patients cannot assert the physician-patient relationship in related lawsuits, the Michigan Supreme Court held.

In *Landelius vs. Sackallares*, the parents of a 7-year-old boy sued the driver of the car that hit the child, according to the Jan. 20 issue of the *National Law Journal*. The driver contended that he lost control of his car when he experienced a seizure. The parents settled with the driver but then sued the University of Michigan and the driver's physician, claiming that the driver should have been diagnosed with epilepsy and not allowed to drive a car.

The driver disclosed his medical records in the automobile negligence case, but refused to release them for the malpractice case. The trial court didn't force the disclosure of the records and granted the driver a summary judgment. The boy's parents then filed another lawsuit against the driver, who tried to invoke the physician-patient privilege to deny access to his records.

The high court stated that by authorizing the disclosure of his medical records in the first case and by giving testimony about his care and treatment, the driver could not prevent those records from becoming part of future related suits.

rules require if necessary, Drake added. "Include a statement that says these [guidelines] are intended to be adapted for different situations in order to enhance and improve the quality of care," he said.

Physicians may want to give their patients an informational handout explaining those policies

that apply to most of their patients, Dr. McCracken said. The handout could include information about how the practice handles after-hours emergencies and how appointments are scheduled. "It's going to be in [the physician's] advantage to have this in writing and let patients know," he said. "It would be

ideal to have patients sign off and say, 'Yes, I understand this.'"

Reasonable, well-considered and current rules can help offices run more efficiently and manage risk, Drake said. "Like any rules or regulations, it's a double-edged sword. If it's a good rule and you follow it, it's great. If it's a bad rule — that's a problem." ■

Television panel

(Continued from page 3)

adulation to anger. One man said he was very satisfied with the way he and his wife had been referred to specialists in their managed care plan. But a woman with lung cancer said she was appalled that she had to go outside of her HMO to get necessary care.

SEVERAL PHYSICIANS in the audience expressed doubts about the likelihood of patients receiving the quality of care they need under managed care. Quentin Young, MD, said he supports legislation

that would allow doctors to set standards of practice. "It's the for-profit, investor-driven arrangement that's killing not only the HMOs but also the American health system," Dr. Young said. "We have to curb excesses and end gag clauses where a doctor may not say something critical of a plan after an owner gets \$2 billion in a sellout."

Hill responded that inappropriate behavior exists in all industries and overall, HMO administrators are working hard and aren't overpaid.

Harry Goldin, MD, a Skokie dermatologist, said he was concerned about patients experiencing difficulty in getting

referrals to specialists. "I find that under managed care, primary care physicians have financial incentives to do more than they are trained to do and not to refer patients to specialists."

Physicians weren't the only ones who expressed concern. The Rev. Davis McCurdy, co-director for the Clinical Health Care Ethics Support Service at the Park Ridge Center in Chicago, said he thinks managed care plans' mandates for shorter hospital stays are a problem.

"Managed care has worked hard to set up systems with home care [providers] to coordinate the care of patients who leave the hospital," Hill responded. "We use

visiting nurses and make sure patients have the correct equipment at home. The pressure to reduce hospital stays is there across all insurance companies."

Although the hour-long broadcast gave representatives from both sides of the managed care debate a chance to express themselves, the complexity of the issues involved left many unanswered questions, host Callaway observed.

Dr. Jackman agreed. "I think the program raised important questions about the quality of care in managed care plans, about the large profits that HMOs are making and about the idea that maybe they're not spending that money on necessary patient care," Dr. Jackman said after the program. "It was great to see Rep. Krause talking about a comprehensive bill that would lead to an equal quality of care for all managed care plans. That is something I would love to see, and I think it would solve most problems." ■

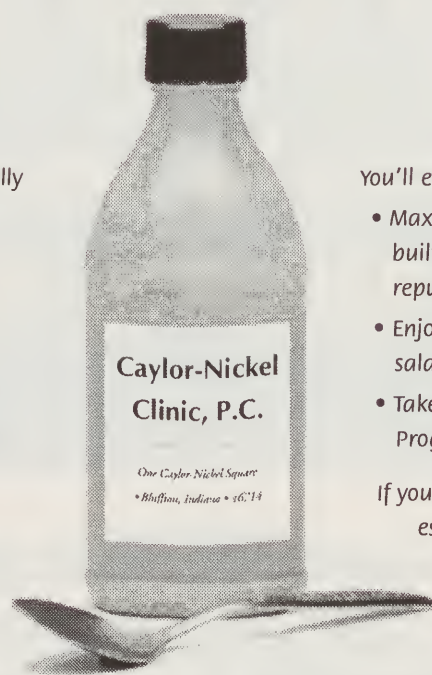
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State infant mortality rate shows small increase

[SPRINGFIELD] Illinois' 1995 infant mortality rate is the second-lowest in the state's history, according to John Lumpkin, MD, director of the Illinois Department of Public Health. The 1995 infant mortality rate is 9.3 deaths for every 1,000 live births, a slight increase from the 1994 rate of 9 infant deaths for every 1,000 live births, reported IDPH.

"We must continue to work together – government agencies with one another, the public sector with the private sector and the medical community with the social services community – to improve each child's chances of being born healthy," Dr. Lumpkin said.

The rate Downstate increased to 7.9 in 1995 from 7.6 in 1994, and the rate in Chicago increased to 12.6 in 1995 from 12.5 in 1994. In 1995, 1,724 infants died before their first birthday compared with 1,711 infants the year before. The 1994 infant mortality rate was the lowest in the state's history.

During the past five years, the state's infant mortality rate has declined 17 percent. Dr. Lumpkin attributed the decline to medical advances, better family case management and a reduction in sudden infant death syndrome cases.

The state assigns case managers to Medicaid recipients and medically indigent families with pregnant women and children up to 1 year old to ensure they receive regular medical care and related services. An IDPH study found that pregnant women without case management were one-third more likely to give birth to very low-birth-weight infants than women who received family management.

SIDS deaths totaled 180 in 1995 – a 28 percent decrease from 1994 and a 41 percent reduction from 1991. The decline may be at least partly due to statewide efforts to educate parents about putting infants to sleep on their backs or sides, according to IDPH.

The infant mortality rate again reflected a racial gap, said Dr. Lumpkin, who added the state faces a continuing challenge to narrow that gap. The disparity – 18.2 deaths for every 1,000 black infants vs. 7.2 deaths for every 1,000 white infants – means that black babies are 2.5 times more likely to die before their first birthday. ■

A prescription for teamwork

Physicians and pharmacists can work in sync to inform patients about medication.

BY DAVE WIETHOP



©Eric Kamp/Phototake NYC

Patients are being hit with more information than ever about new drugs, possible side effects, interactions and potential risks, so it's no wonder they're taking more interest in their prescriptions. Despite advances and patient-directed information about medications, patients' source of that information should remain the same: It should come from their physicians with pharmacists reinforcing doctors' orders and answering last-minute questions.

"Patients would like to get information from physicians," said Silvana Menendez, MD, a Belleville psychiatrist and ISMS 10th District trustee. "If I'm prescribing an antidepressant, I'll explain why I'm prescribing this particular medication and the side effects. I'll also ask if [the patient has] any questions."

Team members are usually most effective when they work together, according to E. Richard Blonsky, MD, a Chicago neurologist. "There is merit to physicians and pharmacists working together. The pharmacist has access to all of the drugs that the patient is taking. The dermatologist may not always know what the patient's allergist has prescribed.

"The physicians will always be the best source for the medication information because they have a better understanding of their patients' clinical issues," Dr. Blonsky continued. "The pharmacists will not necessarily see the patients in this way."

Based on Dr. Blonsky's experience, physicians are routinely explaining medications to their patients and documenting those explanations. He said when he sees the charts of new or referred patients, the records show that previous treating physicians have discussed the side effects and risks of medications with their patients.

Record-keeping has improved in the pharmacies as well. Many pharmacists enter prescription records into databases that contain patients' medication histo-

ries. That way, it's clear if patients are taking similar or counteractive medications prescribed by other physicians. Dr. Menendez said this record-keeping makes it even more important to encourage patients to use one pharmacy or pharmacy network.

The pharmacists' printouts about the drugs, as well as any related brochures, can reinforce the need for complete compliance with the prescription orders and repeat basic information, Dr. Blonsky said. But he added that pharmacists can overstep their roles by unknowingly "scaring the bejeebers out of patients" by discussing possible side effects. Physicians can best explain the frequency of those side effects and patients' level of risk for experiencing them.

In determining what can and cannot be prescribed, some managed care plans have taken a more active role. "Part of the problem is that some managed care programs won't allow a prescription to be filled unless you switch to a generic," said Marshall Blankenship, MD, an Oak Lawn dermatologist who chairs ISMS' Council on Drugs and Therapeutics. "Sometimes you want to use a specific drug for a specific reason and not the generic because of concerns about the content, as opposed to having the drug automatically switched."

In Illinois, it's illegal for pharmacists to substitute generic versions for brand-name drugs if physicians have given specific orders that generics should not be substituted. In addition, the ISMS Board of Trustees actively opposes any state legislation that would authorize pharmacists independently to dispense pharmaceutical or therapeutic substitutes for prescriptions written by physicians.

At its last Annual Meeting, the ISMS House of Delegates adopted a resolution that the Society should inform physicians of their rights, responsibilities and options regarding prescriptions, patient education and ongoing monitoring of pharmaceuticals. The Committee on Drugs and Therapeutics concurred and found that the AMA has policy that physicians should take these steps:

- Keep up with news about pharmaceuticals through literature, AMA drug evaluations, consultations with pharmacists and other physicians, and CME.
- Evaluate patients' health and drug therapies before prescribing medicine to avoid interactions.
- Monitor patients' reactions to prescriptions and regularly evaluate the need for continued drug therapy.
- Remain free to use either brand-name or generic drugs, using their judgment with cost considerations.

Despite the potential for disagreement, physicians and pharmacists can work in sync. Albino Bismonte Jr., MD, a Gurnee pediatrician and ISMS First District trustee, remembers a father who said his child was not allergic to a specific antibiotic. A few hours later, a pharmacist called Dr. Bismonte and said the mother had called the pharmacy because she knew the child was allergic to the drug. "Sometimes the pharmacist can learn things that we won't. I view pharmacists as part of my practice of medicine, not my competitors." ■

On your behalf

ISMS and the ISMS Alliance offer products to help patients track their medications.

The Alliance's Medi-Card allows patients to list allergies, physicians and pharmacies as well as medications. The wallet-sized card is free and available from many county medical society alliances and the ISMS Alliance. For more information or to order the cards, call (312) 782-2099.

ISMS' Healthy Partnership Kit is part of the Partners for

Health program for seniors. The kit contains a personal health record and pamphlets about Medicare, billing, the physician-patient partnership and area agencies on aging. The personal health record is a booklet that allows older patients to record the reasons for each visit to a physician, their current prescriptions and over-the-counter drugs, any new prescription drugs and conditions discussed. To order the free kits, call (312) 782-1654 or (800) 782-ISMS, ext. 1303.

IDPR Disciplines

This information, published as space permits, is reprinted from the Illinois Department of Professional Regulation's monthly disciplinary report. IDPR is solely responsible for its content.

July 1996

Ford Van Hagen, Springfield – physician and surgeon license placed on probation for one year for failing to pay Illinois individual income tax for several tax years.

August 1996

Earl Norman Caldwell, Chicago – physician and surgeon license revoked for

being more than 30 days' delinquent in the payment of child support.

Marion Douglas Dorn, Eldorado – physician and surgeon license placed on probation for an additional three years, terminating Oct. 8, 2000, after violating the terms and conditions of a previously ordered probation.

Ralph Eisaman, Bedford, Texas – physician and surgeon license placed on indefinite probation due to a physical ailment that could prevent him from practicing medicine with a reasonable degree of safety if not properly treated.

James M. Goodrich, Springfield – physician and surgeon license issued and placed on probation until Jan. 1, 2008, due to history of chemical dependency.

Mary E. Marler, Lockport – physician and surgeon license indefinitely suspended after being disciplined in the state of Wyoming.

Lorenzo Maun, Waukegan – physician and surgeon license revoked and fined \$22,000 due to criminal conviction and gross and willful overcharging.

Lorraine Nessler, Chicago – physician and surgeon license indefinitely suspended

ed for failing to pay Illinois income taxes owed for the years 1985 through 1989, failing to file Illinois income tax returns and failing to pay income taxes for the years 1990 through 1992.

Baron Von Baucom, Carbondale – physician and surgeon license restored to probation until he completes payment of delinquent taxes owed the Illinois Department of Revenue.

September 1996

Marion Douglas Dorn, Eldorado – physician and surgeon license indefinitely suspended for failing to comply with the terms and conditions of a previously ordered probation by submitting a urine screen that tested positive for Hydrocodone, a controlled substance.

Joseph Eshaghian, Los Angeles, Calif. – physician and surgeon license placed on probation until June 30, 1998, after being disciplined in the state of California.

Michael Frederick Hase, Aiea, Hawaii – physician and surgeon license placed on probation for six months after the United States Navy allegedly restricted his privileges to practice medicine.

Kimberley A. Hollender, Decatur – physician and surgeon license issued and placed on probation until July 1, 2002, due to a history of depression.

Wayne E. Janda, Coralville, Iowa – physician and surgeon license placed on indefinite probation after being disciplined in the state of Iowa.

Richard K. McDonald, Chicago – physician and surgeon license indefinitely suspended due to an outstanding tax liability owed the Illinois Department of Revenue for the years 1994 and 1995.

Ishfaq A. Pendi, Anaheim Hills, Calif. – physician and surgeon license placed on probation for two years after pleading guilty to a felony, and being disciplined in the state of Michigan.

Steven Taraszka, Atlanta, Ga. – physician and surgeon license indefinitely suspended due to alleged abuse of controlled substances resulting in the inability to practice medicine with reasonable judgment, skill and safety.

October 1996

Mark Baldwin, Chicago – physician and surgeon license indefinitely suspended due to an outstanding tax liability owed the Illinois Department of Revenue for tax years 1989 through 1992.

James Ying Chow, Des Plaines – physician and surgeon license indefinitely suspended for employing an individual not licensed under the Medical Practice Act to perform acupuncture in his offices.

Byron Glenn, Cape Girardeau, Mo. – physician and surgeon license placed on indefinite probation after allegedly being in possession of cocaine.

Ruben A. Inocencio, Chicago – physician and surgeon license placed on indefinite probation and controlled substance license indefinitely suspended for aiding and abetting the unlicensed practice of medicine and ordering controlled substances to be dispensed in his medical practice without ensuring that adequate security measures were taken to prevent diversion.

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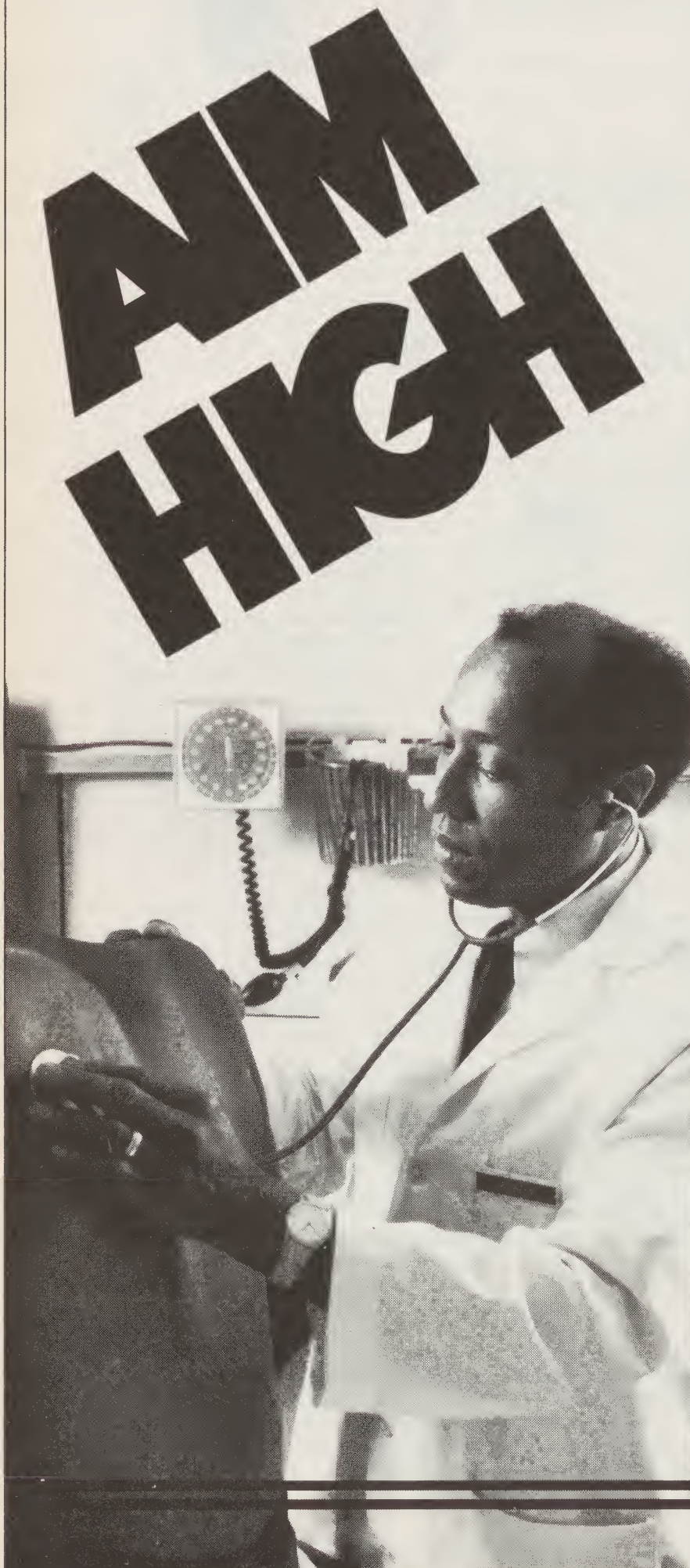
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OBITUARIES

**Indicates member of ISMS Fifty Year Club*

D'Andrea

Maurice J. D'Andrea, MD, an abdominal surgeon from Oak Lawn, died Dec. 12, 1996, at the age of 79. Dr. D'Andrea was a 1942 graduate of the Chicago Medical School, Chicago.

Fine

Michael Fine, MD, a radiologist from Chicago, died Dec. 2, 1996, at the age of 50. Dr. Fine was a 1969 graduate of the Medical School University of the Witwatersrand, Johannesburg, South Africa.

Friedman

Louis B. Friedman, MD, a general practitioner from Chicago, died Dec. 23, 1996, at the age of 89. Dr. Friedman was a 1940 graduate of the Chicago Medical School, Chicago.

Gingold

Walter Gingold, MD, a general practitioner from Highland Park, died Jan. 7 at the age of 83. Dr. Gingold was a 1938 graduate of the Medizinische Fakultät der Universität Wien, Wien, Germany.

Huggins

Charles B. Huggins, MD, a urologist from Chicago, died Jan. 12 at the age of 95. Dr. Huggins was a 1924 graduate of the Harvard Medical School, Boston, Mass.

*Raber

Paul A. Raber, MD, a gynecologist from Clearwater, Fla., formerly of Decatur, died Jan. 9 at the age of 82. Dr. Raber was a 1941 graduate of the Northwestern University Medical School, Chicago.

*Shuman

Harry W. Shuman, MD, an internist from Rock Island, died Dec. 11, 1996, at the age of 98. Dr. Shuman was a 1926 graduate of the Loyola University Stritch School of Medicine, Maywood.

Tachdjian

Mihran Tachdjian, MD, an orthopedic surgeon from Chicago, died Dec. 2, 1996, at the age of 69. Dr. Tachdjian was a 1952 graduate of the Medical School, American University of Beirut, Beirut, Lebanon.

Van Nuys

John D. Van Nuys, MD, an otolaryngologist from Lake Bluff, died Jan. 2 at the age of 70. Dr. Van Nuys was a 1955 graduate of the Loyola University Stritch School of Medicine, Maywood.

*Weisberg

Seymour W. Weisberg, MD, an internist from Chicago, died Dec. 19, 1996, at the age of 86. Dr. Weisberg was a 1937 graduate of the Rush Medical College, Chicago.

RUSSIAN PHYSICIANS Oleg Ye Nifantiev, MD (center), and Ashot Sarkisyan, MD (right), confer with ISMS member Yammanuru Ramulu, MD, during their tour of the radiology department at Delnor-Community Hospital in Geneva. The Kane County Medical Society and Dreyer Medical Clinic hosted the Jan. 24 visit by leaders of the Russian Medical Association.



Terry Vitacco

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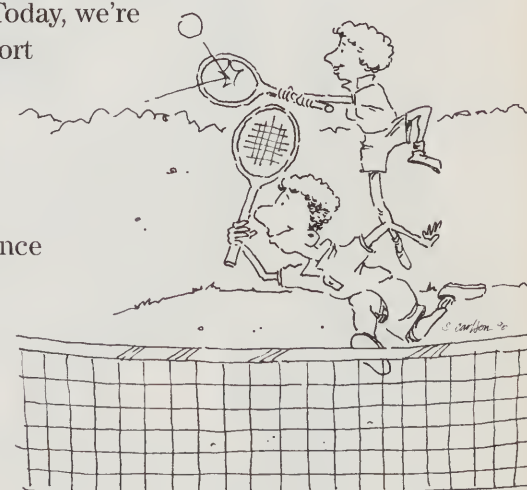
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Physicians' Access Services



Act guarantees basic patient rights

The Managed Care Patient Rights Act guarantees patients certain basic rights and prevents plans from requiring patients to waive, restrict or limit those rights to get benefits. The basic rights specified in the bill are

- Quality health services as guaranteed by the patient's health insurance plan
- Freedom of choice of physician to coordinate health care
- Confidence that physicians and other health care providers are free to advocate on behalf of their patients for medically necessary health care
- A point-of-service option to allow freedom of choice of health care providers and access to services that aren't offered or approved by the plan
- Clear and understandable information regarding the terms and conditions of managed care plans and health insurance
- Information on managed care plan performance in providing quality care
- Privacy and confidentiality in health care services
- Knowledge of the identity of the patient's participating providers
- A reasonable explanation of the plan for the patient's care
- A reasonable explanation of bills for services
- Protection from revocation of prior authorization once health care services have been provided
- Prohibition of prior authorization requirements for emergency care
- Timely and clear notification when the patient's managed care plan discontinues the patient's coverage or terminates the contract of the patient's physician

Patient rights bill

(Continued from page 1)

the managed care issues in a piecemeal fashion is that those changes can be dismissed as being motivated by political expediency," said Rep. Jeff Schoenberg (D-Evanston), the bill's lead sponsor in the Illinois House and vice chairman of the Human Services Committee. "A comprehensive approach to such a complex issue as managed care is the most responsible. This bipartisan initiative will take a comprehensive approach toward providing greater balance in the health care decision-making process."

One provision of MCPRA prohibits gag rules, which preclude physicians and other health care providers from talking to patients about critical information like treatment options. The bill would ban plan retaliation against physicians who speak out on behalf of their patients.

"Gag rules interfere with the communication between a doctor and the patient and can undermine the doctor-patient relationship, which we think is the very foundation of good medical care," Dr. Olson said.

MCPRA also requires plans to disclose clear, understandable and timely information about coverage inclusions and exclusions. "As patients begin to experience managed care, they are not aware of exactly what is covered and not covered," said Rep. Carolyn Krause (R-Mt. Prospect), a co-sponsor of the bill. In addition, patients may not know how to get approval for care.

The bill would require plans to notify patients of approvals and denials of services. If services are denied, notices must include the signature of the individual who made the decision and details about how to appeal that decision. Enrollees must also be notified if their physicians leave or are terminated from the plan or if their health coverage is stopped.

MCPRA expands choice of physician by allowing patients "with an ongoing, recurring or chronic disease or condition" to choose a "principal care physician," who must be a member of the plan and must have a referral arrange-

MCPRA reflects ISMS positions, policies

The Managed Care Patient Rights Act, a comprehensive patient protection bill, was developed from more than 35 ISMS positions and policies on managed care and other related health care issues. "The principles behind the [bill] grew largely out of policies that were passed by the House of Delegates over the last several years," said ISMS President Sandra Olson, MD. "Physicians were increasingly encountering problems, and they used this process to try to address them."

MCPRA was first introduced into the Illinois General Assembly in February 1996. Unlike some narrowly focused managed care bills, MCPRA didn't pass the General Assembly because legislators needed more time to analyze the measure's comprehensive provisions. In the intervening year, ISMS' Council on Economics, Governmental Affairs Council, Third Party Payment Processes Committee and Board of Trustees have continued refining the bill's provisions to better reflect Society policies while incorporating some suggestions from other physician and medical organizations. At its Feb. 1 meeting, the Board of Trustees approved the revision of MCPRA and its reintroduction into the General Assembly.

The legislation reflects a broad range of ISMS positions and policies on issues such as patients' choice of physician, utilization review, economic credentialing, cost containment, due process, hospital and medical staff committees, medical diagnosis and treatment, the corporate practice of medicine, confidentiality and emergency medical care.

In addition, MCPRA encompasses all or part of ISMS' positions and policies on arbitrary denial of qualified physician participation in managed care plans, COBRA regulations, the code of ethics, freedom of choice, freedom to contract, health care system reform principles, health insurance, voluntary plans, hold-harmless clauses in managed care contracts, managed care consumer protection law, managed care insurance company credentialing, pre-admission certification, state legislation mandating disclosure of financial interest in physician referrals, third-party intrusion into medical judgment and gag rules.

"If approved by the General Assembly and signed by the governor, MCPRA will fill the need for legislation that balances patient rights with the reality of today's managed care environment," Dr. Olson said.

ment with the primary care physician. This provision would allow cancer patients, for example, to see their oncologists regularly without prior referrals and authorization from their primary care physicians.

Plans must also offer a point-of-service feature that would allow patients to go outside their plans to access nonmember physicians and health care providers, as well as to get additional services without referrals, prior authorization or other review requirements, according to MCPRA. Patients would pay an addi-

tional fee to have the feature.

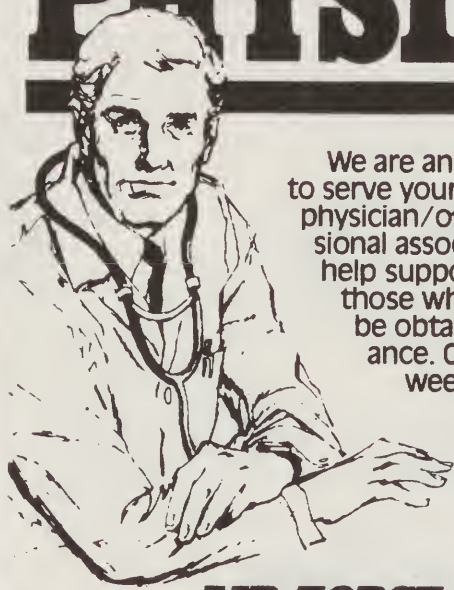
The bill also requires managed care plans to create quality assurance plans, drawing on patient grievances and their resolution. Under MCPRA, managed care plans will be certified and regulated by appropriate state agencies to ensure that the plans meet minimum standards set out in the act.

Medical decisions will be left in the hands of the plans' practicing physicians, Dr. Olson explained. MCPRA establishes that each plan have an independent medical review board whose members are elected from the plan's medical staff. The board will have significant input into the "medical policy, utilization review criteria and procedures, quality assurance procedures and credentialing criteria and medical management procedures," according to the bill.

"It seems to me that this act will provide Illinois citizens with a greater sense of assurance and security so that when [they are] undergoing a serious health challenge, they don't have to compound it with serious concerns over their rights as a patient," said Sen. Penny Severns (D-Decatur), the bill's co-sponsor in the Senate. "While we don't naively believe that this legislation will solve all problems, it is committed to helping to provide solutions."

Managed care entities have yet to solve many of the problems that the public has expressed, said Rep. Tom Cross (R-Yorkville), a co-sponsor of the bill in the House. MCPRA addresses those concerns in a fair and reasonable way, he added. "This bill will not destroy managed care. Managed care is here to stay, and managed care has a place in our society. But we need to make some adjustments, and that's what this bill does."

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Court battles

(Continued from page 1)

not pre-empted by ERISA. As a result of the Travelers case, a few states have won battles over ERISA. One such case occurred in Connecticut last year when the state Superior Court overturned a lower court decision in *Napoletano et al. vs. CIGNA Healthcare of Connecticut*.

In 1994, Robert S. Napoletano, MD, claimed he had been terminated from CIGNA's plan without just cause, violating a state law that requires insurers to disclose the criteria for termination. The lower court threw out the case under ERISA, but Dr. Napoletano – with legal and financial help from the Connecticut State Medical Society and the AMA – appealed the decision. In July 1996, the state Superior Court, citing the U.S. Supreme Court's *Travelers* decision, overturned the lower court's ruling and returned the case for proceedings.

In its ruling, the state Superior Court noted that "the Napoletano plaintiffs reasonably believed that they would continue to be providers under the plan" as long as they met the criteria required by the CIGNA contracts.

The decision, said CSMS Executive Director Tim Norbeck, is "a significant

victory" for both physicians and patients. "Connecticut is a very tough state because we're the insurance capital of the country. We had been fearful that any managed care reform that we tried to advance would be turned away because those legislators who back the insurers would simply say, 'Why should we bother as long as there is ERISA?' But now I sense that the tide is turning."

The issue affects many Illinoisans and Americans. According to the U.S. Department of Labor, about 65 percent of Illinois workers and more than one-half of all U.S. workers are enrolled in self-insured plans. Laura Tobler, research

analyst at the National Conference of State Legislatures, said that states feel "plagued" by the federal law. "I think states would welcome a re-examination of ERISA by the federal government. Legislators have watched more and more employers in their states go into self-funding merely to get out of the regulations imposed by the law. So all of this reform that they've been working on has only applied to nonself-funded entities."

Ted Lewers, MD, a member of the AMA Board of Trustees, said the AMA advocates an update of ERISA. "If the managed care industry is controlling the decision-making and the practice of

medicine, they should be accountable. They are trying to shift all this responsibility for their managed care onto physicians, and it's just not right."

ISMS' Health Care Reform Principles state that self-insured plans should not be exempt from state laws under ERISA.

As for what doctors can do, Dr. Lewers said, "We have to do what is best for the patient and stand up when someone is trying to limit the care delivered to the patients that we know is correct. We have to basically fight those situations where our right to practice medicine and make decisions is being usurped. As long as we do that, we're going to be all right." ■

Governor tackles

(Continued from page 1)

money by eliminating overlapping and duplicated services, instead offering "a streamlined, one-stop shopping approach to service delivery," Edgar said. "Many of the needy have been dealing with several case managers and often receive conflicting advice. Now there will be one case manager to focus on the big picture when dealing with families and individuals."

Programs from the following departments will be consolidated: Public Aid, Alcoholism and Substance Abuse, Public Health, Children and Family Services, Mental Health and Developmental Disabilities, and Rehabilitation Services. The Department of Human Services will have a \$4 billion budget and 20,000 employees.

Edgar also said the state will continue with mental health reforms. Connect 97, launched in October 1996, will provide \$7.2 million in grants this year to improve community-based services.

Money distributed through the program will be used to establish toll-free telephone numbers for each state hospital, so discharged patients can stay in contact, and to improve access to mental health services for young people.

"By assuring better community treatment services for people being discharged from state hospitals, far fewer are finding it necessary to return," Edgar said. ■

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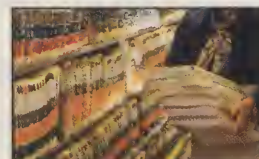


*ISMS, ITLA,
Supreme Court
focus on tort
reform challenges*

PAGE 7

Illinois Medicine

ILLINOIS STATE MEDICAL SOCIETY • FEBRUARY 28 1997



*Loose lips, sloppy
record-keeping can
create liability*

PAGE 6

Brian Waring



GATHERED FOR A Feb. 10 news conference to announce the development of a bill that would stop discrimination in mental health insurance coverage in Illinois are (from left) Rep. Judy Erwin (D-Chicago); Sen. Thomas Walsh (R-Westchester); Rep. Lauren Beth Gash (D-Deerfield); Arden Barnett, MD; Alliance for the Mentally Ill-Illinois President Linda Virgil; and Illinois Psychiatric Society President-elect Valerie Raskin, MD.

Hines VA to streamline services through telepathology

INNOVATION: Hospital will serve as a resource in a new telemedicine network. BY KAREN TITUS

[HINES] With resources growing increasingly tighter, the Department of Veterans Affairs, Edward Hines Jr. Hospital in Hines has turned to telecommunications technology to increase access to medical advances.

The first big step is scheduled to occur this spring, when Hines' pathology department will link with the pathology departments at Zablocki VA Medical Center in Milwaukee and Veterans Affairs Medical Center in Iron Mountain, Mich.

The move will open the door for additional excursions into telemedicine, said Gregorio Chejfec, MD, chief of pathology and laboratory medicine services at Hines VA. "The telemedicine movement is not restricted to pathology. The VA is opening programs in teleradiology, telepsychology, teledentistry, teleneurology and teledermatology."

If everything works according to plan, all VAs will be able to communicate with one another via telemedicine, according to Dr. Chejfec. "We have to streamline the VA system in general," he explained, pointing to regional

budget cuts of \$8 million in fiscal year 1997 and \$40 million in fiscal 1998. "We are consolidating facilities and want to avoid duplication of services. We have a shrinking patient population." Telepathology and ultimately telemedicine may be at least part of the solution, he said.

Under the system, Hines joins the telepathology link between Iron Mountain and Milwaukee, which was established last August when Iron Mountain's sole pathologist retired. Rather than filling that position, Iron Mountain trained a medical technologist as a pathologist assistant to prepare specimens. The hospital also installed an imaging system capable of producing static and real-time specimen images, said Bruce Dunn, MD, chief of laboratory and manager of the hospital medical services division at the Zablocki VA. Iron Mountain's VA now sends cases to the Milwaukee hospital where they are handled by the four staff pathologists, and Hines VA will serve as another resource for consultations.

(Continued on page 11)

MCPRA aims to establish independent medical staffs

PATIENT RIGHTS: Panels in managed care plans would operate much like hospital medical staffs. BY JANE ZENTMYER

[SPRINGFIELD] Patients who have experienced drive-through hospital procedures over their physicians' objections know firsthand the influence that managed care plans wield in treatment decisions. The

1997 Managed Care Patient Rights Act "makes it very clear that medical decisions belong in the hands of the practicing doctors in the plans," said ISMS President Sandra Olson, MD.

MCPRA is a bipartisan, comprehensive bill that aims to protect managed care patients from plan practices that might compromise the quality of patient care. On Feb. 6, H.B. 603 was introduced in the Illinois House with 40 sponsors and S.B. 705 was introduced in the Senate with 10 sponsors.

Sponsors include Sens. Dan Cronin (R-Elmhurst), Penny Severns (D-Decatur), Doris Karpel (R-Roselle), Denny Jacobs (D-Moline) and James Clayborne (D-Belleville); and Reps. Jeff Schoenberg (D-Wil-

mette), Tom Cross (R-Yorkville), Judy Erwin (D-Chicago), Carolyn Krause (R-Mt. Prospect) and Mary Flowers (D-Chicago).

One provision of the bill would create independent medical staffs within managed care plans. Those panels would have significant input into developing the plans' medical policies, utilization review criteria and procedures, quality assurance procedures and credentialing criteria and medical management procedures. Only physicians participating in the plans could be members of the medical staffs.

These staffs would also elect physicians to medical review boards that would be representative of various specialties and geographic areas. Board mem-

(Continued on page 8)

INSIDE

**ISMS loans
help students
make it through
medical school**



PAGE 2

**State access law
applies to ERISA
health plans**

PAGE 2

**General Assembly
considers bills
reflecting ISMS
resolutions**



PAGE 3

DEPARTMENTS

Commentary.....4

**Malpractice
Roundup.....6**

Classifieds9

Illinois physicians opt for MSAs

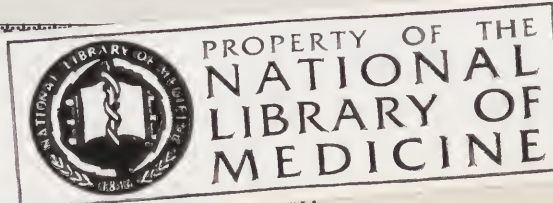
PILOT PROGRAM: Doctors who meet the law's requirements can sign up. BY JANE ZENTMYER

[CHICAGO] After examining the options available through medical savings accounts, some physicians – like Peter Brusca, MD – have said they believe MSAs offer benefits that other insurance plans don't. MSAs became available across the country Jan. 1 thanks to the 1996 Kassebaum-Kennedy legislation.

"I had my accountant look it over, and he said it was definitely a plus from a tax point of view," said Dr. Brusca, an otorhinolaryngologist and a member of ISMIE's Board of Governors. "And from a medical point of view, I definitely think it's a plus. You still have your choices of your medical plan insurance."

MSAs pair high-deductible insurance policies with tax-free savings accounts. The annual contributions can be withdrawn for medical expenses as defined by the U.S. tax code, and the withdrawals aren't subject to federal income tax. Funds withdrawn for purposes other than medical expenses, however, are taxed and penalized by a 15 percent charge. If no money is taken from the account, it rolls over to the next year, and another deposit can be made to the MSA. Investment gains in the account are tax free, said Bruce Matthews, administrator of the Physicians' Benefits Trust. ISMS and the AMA support MSAs.

(Continued on page 11)



ISMS loans help students pay the price for medical school

Program eases debt and makes students aware of the benefits of Society membership. BY JANE ZENTMYER

Paying for medical school has never been easy, especially with tuition increases. That's why medical students typically need financial aid, and some seek help through the ISMS Medical Student Loan Program.

During the 1995-96 school year, students at private medical schools spent an average of \$23,696 on tuition and fees, and those attending public school spent an average of \$8,715, according to the Association of American Medical Colleges. In 1994, 79 percent of medical school graduates reported some debt, and most faced an average debt of \$63,885, according to the AMA.

"Medical school is amazingly expensive," said Michael Terry, a third-year medical student at the University of Chicago and a member of the ISMS Committee on Financial Aid to Medical Students. "The ISMS loan program is a great program done for all the right reasons. It provides a tremendous benefit to a lot of students."

The program began during the 1983-

84 school year with eight Illinois medical schools receiving a total of \$41,650 for 24 student loans. Twelve years later, ISMS granted \$295,260 for 127 student loans. During the program's existence, 945 loan recipients have received more than \$1.9 million.

"It's been extremely successful," said Edward Fesco, MD, 2nd District trustee and chairman of the Committee on Financial Aid to Medical Students. Donations and fund-raising events by ISMS and the ISMS

Alliance provided money to start the loan program, he said. Today, the funds come from membership dues, donations and loan payments from former students.

ISMS approved \$350,000 as student loan allocations for the current school year. The money is distributed to medical schools based on a formula that takes student enrollment into account. The schools' financial aid officials then select the recipients. To become eligible for an ISMS loan, students must be in their second, third or fourth year at an Illinois medical school, receive the endorsement

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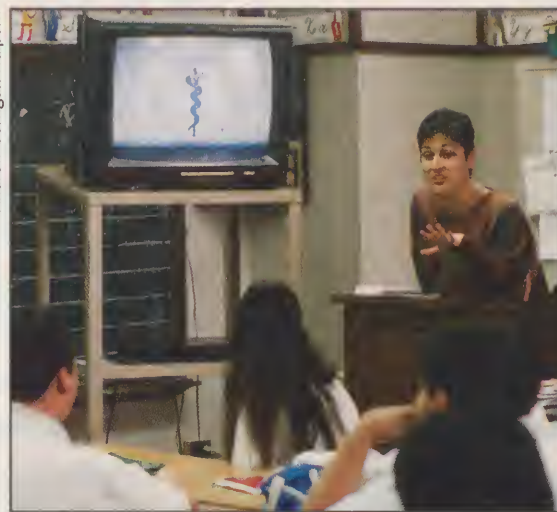
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STUDENTS AT Chicago's Hamline Elementary School listen to Raynelda Hidalgo, MD, as she presents the ISMS video "Straight Talk to Teens About Sex, AIDS and Disease" on Feb. 11. Dr. Hidalgo is a volunteer in the ISMS Speakers Bureau, which coordinates physician presentations on health issues related to seniors and teens.

of their schools' financial aid offices, be an Illinois resident and become an ISMS student member.

When the program began, loans were limited to \$2,500 so that more students could get them. But with the increasing costs of medical school, the committee voted in August 1996 to increase the loan to a maximum of \$4,000 per loan, Dr. Fesco said.

Loan recipients do not have to begin payments on the principal and the 5.5 percent annual administrative fee, or interest, until Jan. 1 of the first year of practice following completion of postgraduate training, or five years after medical school graduation.

"The main benefit to the student loans is that they're at an interest rate that is manageable – or at least more manageable than some of the other loans that are out there," Terry said. "It makes the enormous debt that you have to acquire during medical school a bit more palatable."

During the 1992-93 academic year, ISMS launched a loan program for students who plan on primary care careers. The program waives the 5.5 percent annual administrative fee for students who complete residencies and begin practice in primary care. "They just have to pay back the principal that they bor-

row," Dr. Fesco explained.

Most students repay their loans, Dr. Fesco said, adding that "sometimes the [payments] have to be delayed." For example, one former student asked ISMS if he could reduce his monthly payments temporarily. He had good reason: The birth of triplets in his family – in addition to 2-year-old twins – stretched this new physician's budget. The request was granted.

The loan program has a benefit beyond the obvious. Through it, students learn about other ISMS programs, Dr. Fesco said. "By being acquainted with the state medical society and becoming student members, they can realize the benefits of membership."

Terry said that when he attended his first meeting of the Committee on Financial Aid to Medical Students, he was impressed that the physicians on the panel donated their time to get as much money as possible to the students for no other reason than to help others. "What struck me was that we really have these advocates in ISMS whom we didn't necessarily know about," he said.

Physicians who would like to contribute to the loan program may call ISMS at (312) 782-1654 or (800) 782-ISMS.

State access law applies to ERISA health plans

[CHICAGO] To answer questions from health care providers, the Illinois Department of Insurance reiterated in January its position that a law allowing women direct access to their obstetrician or gynecologist applies to all health plans, including those that are self-insured.

If a patient in an Employee Retirement and Income Security Act plan complained to the department that the insurer didn't comply with state law, that plan would be held to the same standards as those of a managed care program, wrote IDOI Assistant Deputy Director Ronald Kotowski in response to questions from the American College of Obstetricians and Gynecologists. "If the plan did not comply, the department would refer the complaint to the Illinois Attorney General's Office for enforcement," Kotowski wrote.

Health plans must comply with this law as their contracts are amended, issued, delivered or renewed following the effective date of the law, which was Nov. 14, 1996. The law requires plans to allow women to choose a "women's principal health care provider," defined

as a "physician licensed to practice in all of its branches specializing in obstetrics or gynecology."

Surveys have shown that women are more likely to see their obstetrician or gynecologist than any other type of physician, and Illinois legislators passed this law to grant women access to the physicians they are most likely to see. The law supports a position adopted by the ISMS House of Delegates in 1995 and reaffirmed in 1996.

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General Assembly to consider bills reflecting ISMS proposals

CONSENSUS: Society's Board of Trustees approves draft legislation.

BY JANE ZENTMYER

[SPRINGFIELD] At its Feb. 1 meeting, the ISMS Board of Trustees approved draft legislation that ISMS will support during the Illinois General Assembly's current legislative session. Prior to the board meeting, various ISMS councils and committees, including the Governmental Affairs Council, reviewed the measures and compared them with positions and policies of the Society's House of Delegates. The bills included the following:

ANTI-SMOKING INITIATIVES

Reps. Tom Ryder (R-Jerseyville) and Douglas Scott (D-Rockford) are sponsors of H.B. 359, which prohibits tobacco companies and product distributors from disseminating free product samples. A related measure, S.B. 219, sponsored by Sen. Kathleen Parker (R-Northfield), bans the sale of cigarettes in packs of less than 20 and prohibits the distribution of free tobacco samples. Both bills outline penalties for violating the law. They also are consistent with a resolution the HOD adopted last April, which said tobacco companies have a vested interest in inducing customers to try these highly addictive products.

H.B. 570, sponsored by Rep. Daniel Burke (D-Chicago), would amend the Illinois Clean Indoor Air Act by banning smoking in all hospitals, ambulatory surgical treatment centers, postsurgical recovery centers, nursing homes, physicians' and dentists' offices and all other health care facilities. The bill reflects an HOD-approved resolution stating that legislation is needed because smoking continues to be a major cause of death and illness but is still prevalent in health care facilities, since voluntary anti-smoking efforts have not succeeded.

A fourth bill, which mirrors an HOD-approved resolution, amends the Clean Indoor Air Act to ban tobacco use in restaurants. Rep. Carolyn Krause (R-Mt. Prospect) is the sponsor of H.B. 567.

TATTOO ARTIST LICENSURE

Sponsored by Rep. Sara Feigenholtz (D-Chicago), H.B. 536 requires the Illinois Department of Professional Regulation to license tattoo artists. It also directs IDPR to establish rules on sanitation, sterilization and hygiene; administer tests; collect license fees; conduct investigations of violations; and penalize those who violate the act. Additionally, tattoo artists must pass a licensure exam.

The bill was developed, in part, because of concerns that tattoo equipment may not be sterile and may contribute to the spread of infectious diseases. The bill reflects an ISMS position.

LEAD POISONING BLOOD TEST RESULTS

Sen. Dave Syverson (R-Rockford) is the sponsor of a measure that amends the reporting procedures for the results of blood lead tests. S.B. 247 calls for only positive results to be reported within 48 hours to the Illinois Department of Public Health. The law now requires all results to be reported within that time frame. The bill states that negative test

results must be reported no later than 30 days after the end of the month in which they are received.

This measure mirrors a resolution adopted at the 1996 Annual Meeting. According to the resolution, reporting all blood lead analyses within 48 hours

strains IDPH's resources and puts undue pressure on those who analyze the tests.

GOOD SAMARITAN COVERAGE

A physician's presence can be a plus at sporting events when injuries or illnesses occur, but doctors may incur liability through their volunteer activities at these events. In keeping with an HOD-approved resolution, H.B. 365, sponsored by Rep. Jay Ackerman (R-Morton), grants immunity from civil liability to physicians who volunteer at sports, religious or public events. Exceptions are cases of willful and wanton misconduct.

PHYSICIAN PARTICIPATION IN EXECUTIONS

A 1996 HOD resolution called for a renewed legislative initiative to exclude physicians from participating in executions. Sen. Arthur Berman (D-Chicago) introduced S.B. 393, which deletes a Medical Practice Act provision that currently exempts those who carry out executions from state disciplinary action.

The measure states that the local coroner – not a physician – will pronounce death after an execution, with the death certified by a physician. The bill also eliminates confidentiality for physicians who participate in executions. ■



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REPORT for Illinois Physicians

New Local Modifier for "Incident to" Services

This Medicare carrier is instituting a local modifier, YR services performed by another provider, but billed as services performed "incident to" the personal professional services of the billing physician/non-physician. This modifier is being instituted to identify the billing of services performed "incident to" the personal professional services of a physician. Certain non-physician providers' services are also covered under the "incident to" provision and are included in the use of this modifier. Beginning January 1, 1997, services provided "incident to" the personal professional services of a physician/non-physician must be billed using the YR modifier, and attached to all personal professional services performed "incident to" which may be identified by a CPT* or HCPCS level I, or II code. In general, "incident to" services are services performed by a physician's or non-physician provider's employee, but billed on the claim as if the billing physician or non-physician provider himself/herself had provided the service.

Although there are instances when the provider and provider's employee collaborate on a service, this modifier should be attached to service codes when the employee performed the service predominantly without the provider's collaboration.

This modifier is not to be used for the billing for laboratory tests, supplies, drugs, biologicals, and all procedure codes billed with a TC modifier. A more comprehensive list of exclusions appears in the December, 1996, Medicare B Bulletin.

Section 1861(s)(2)(A) of the Social Security Act (the Act) provides for coverage of services under the "incident to" provision. In order for such services to be covered, certain conditions must be met in addition to the standard coverage criteria that are applicable (see MCM 2050.2, 2050.3, 2050.4). The services must be:

- an integral, although incidental, part of a professional service of a physician;
- of a kind that is commonly furnished in physicians' offices;
- either rendered without charge or included in the physician's bill
- representative of an expense incurred by the physician/non-physician in his/her professional practice;
- performed under the direct supervision of the physician/non-physician provider;
- performed by an employee of the physician/non-physician (or the physician directed center); and
- initiated and managed by the employing physician/non-physician

*CPT five-digit codes, two-digit numeric modifiers, and descriptions only are © 1996 American Medical Association

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EDITORIAL

Cause and effect

Establishing cause and effect can get you into trouble sometimes. A federal judge in Oregon recently threw plaintiffs' experts out of court for using the theory that breast implants cause such maladies as connective tissue disease. The judge accused the experts of seeing patterns where there were none. But sometimes cause and effect are verifiable – for example, in the way ISMS operates.

The causes, or catalysts, are the resolutions submitted at the House of Delegates Annual Meeting. They can come from delegates, other voting members of the house or county medical societies. Delegates don't necessarily propose only their own ideas; they're responsible for listening to grass-roots physicians and translating what they hear into resolutions that outline problems and solutions and that can actually be implemented. That's why physicians get the best representation when they discuss their concerns with individual delegates or at county medical society meetings.

Before the Annual Meeting, the speaker of the house assigns resolutions to reference committees for debate. Any ISMS member can attend those debates and speak out on any issue. After the debate ends, the reference committee members synthesize the discussion and develop recommendations on each resolution for the house to consider. The full HOD then reviews those recommendations and votes on them.

The house may vote to adopt a resolution, requiring the Board of Trustees to carry out the intent of the resolution as soon as possible. The board then assigns the resolution to an ISMS council or committee, which recommends a way to implement it. The house also has the options of rejecting the resolution; offering a substitute; or referring it to the board for report, decision or national action.

If the process sounds as if it involves a lot of work and has checks and balances, that's because it does. It allows for ample discussion, debate, argument and revision at several stages. But the results are well worth the effort: A resolution may end up as state legislation.

In January, the Governmental Affairs Council reviewed a full agenda of draft legislation and the resolutions that related to each bill. The council considered whether the draft bills met the intent of the resolutions, and in February, the board did the same thing at its meeting. Only after the board approved draft legislation stemming from HOD resolutions were those bills introduced into the General Assembly.

You'll read about the results of at least a year's worth of activity in this issue. The Managed Care Patient Rights Act covered on page 1 and the bills described on page 3 all came about through the process. So when you read about ISMS-developed legislation, don't forget the part you have played – and will continue playing – in helping resolutions turn into realities.

PRESIDENT'S LETTER

The Managed Care Patient Rights Act

Sandra F. Olson, MD



Apart from its value for patients and doctors, MCPRA is an excellent example of the result of your efforts at ISMS.

I've had the opportunity to talk to many of you about the Managed Care Patient Rights Act. This legislation was introduced into the Statehouse one year ago and was supported by more than 40 legislators on both sides of the aisle and in both houses. As you also know, it was not passed last year, which was no surprise. ISMS has received many comments about the law and has met with any group that wanted to discuss the act. Based on this input, changes have been made, and I think the legislation has been strengthened considerably.

I'd like to review the origin of this legislation. What are the main principles on which it is based?

- The right to quality care under managed care plans
- The right to choose a doctor
- The right to know the doctor is working as a patient advocate, free from managed care "gag rules" and other restrictions
- The right of a doctor to work with the patient to make decisions based upon the patient's individual medical needs
- The right to clear, timely and understandable information from a managed care plan

The act also specifies the mechanisms that will ensure these rights. Where did all of these points come from? The answer is they came from you. Let me explain.

Over the last three to five years, you, the members, have introduced resolutions into the ISMS House of Delegates that led to the formulation and articulation of the principles in MCPRA. Sometimes these resolutions have reflected problems you have seen with your patients or issues the public has brought to our attention and asked us to address. It's important to understand that these proposed rights have evolved in response to these problems. The legisla-

tion was not drafted on a whim. After much thoughtful discussion and committee review, the act was revised and reintroduced into both houses of the Legislature on Feb. 6, 1997. At this writing, we have 40 representatives and 10 senators as sponsors. The support is again obviously strong and bipartisan. But apart from its value for patients and doctors, MCPRA is an excellent example of the result of your efforts at ISMS.

Let's turn to what you can continue to do through your medical society, and that is to develop and introduce resolutions to address problems and issues that you encounter, that your colleagues raise at your hospital or that your patients relate. That's how we get things done as a society and fight for our patients. Let me give you a specific example. One of the basic rights codified in the Managed Care Patient Rights Act is freedom for patients to choose their doctor. This particular issue has been addressed many times in our House of Delegates and goes back as far as 1986. Then it was reaffirmed at the 1995 meeting through Resolution 59 and again in 1996. Another important and obvious example is that physicians should have due process in managed care plans. This arose in 1994 through Substitute Resolution 48.

Now is the time for you to bring issues forward; resolutions, which must be introduced by a delegate, are due March 18. If you are not sure about the mechanics, you only have to call your county medical society or ISMS, and they would be happy to help. This process is what it's about. This is how we accomplish change as a society: through our collective wisdom and our efforts on behalf of our members and patients. We debate the issues together as a society and issue our final policies, which can lead to a specific piece of legislation like MCPRA. This is how our work provides tangible benefits to our patients, our members and our society at large. Go for it.

GUEST EDITORIAL

Kids' health must be top priority

By Mark Rosenberg, MD

As physicians, we sometimes encounter families that are unable to afford costly immunizations or parents who ask for less-expensive antibiotics for their children. Families may even leave their doctors altogether to seek public health clinics for their youngsters.

Most disturbing are families that go without medical attention because they lack insurance coverage for catastrophic illnesses or their single-parent incomes don't stretch enough to include health care. Although we may not be able to predict the long-term medical problems that uninsured families will eventually face, we can understand some of the characteristics of families who make up these groups.

People may have some misconceptions about the uninsured — for instance, that they're unemployed, belong to a minority group and live in the inner city. However, four of five Illinois families have at least one working parent, and the vast majority are white and live in rural areas of the state. Those most affected by the lack of health insurance are the dependents in the families, most often the children.

The nonprofit group Voices for Illinois Children recently released the "Illinois Kids Count" report, which provides a glimpse of the vulnerability of Illinois children and compares them with children in other states. Among Illinois children under 6 years of age, one in four lives in poverty, and among Illinois children of all ages, one in five falls into that group. Of all Illinois infants, one in seven is born to a single, teen-age mother who hasn't completed high school. Two of three infants with developmental delays fail to receive early intervention with educational and therapeutic services.

On the plus side, infant mortality rates in our state have continued to decline over the past several years, with Illinois ranking in the lowest one-fifth of the states. Yet there's a persistent discrepancy between white and black infant mortality rates.

The problems documented by Kids Count are complex, but this trend of deteriorating living conditions and insufficient health care for Illinois children is disturbing and demands our attention. Recent research into the developing brain has helped us recognize critical intervention points at which children's development may be influenced. Once passed, those opportunities may be missed forever. Consider the child whose mother fails to receive prenatal care to avoid a preterm birth. That child's development has been altered, and an early intervention opportunity has been missed.

To influence the development and success of children, there is much that communities can do. For example, they can focus on the quality of early childhood education, parental support, adequate nutrition and the availability of access to health care.

One solution is to expand low-income families' access to health care. Currently, a family of four with an income of less than \$15,600 qualifies for Medicaid. As more families move from welfare to work, they will need support

for that transition period. Since few employers provide dependent health care coverage for low-income employees, families must weigh their abilities to afford health insurance against other competing family needs.

One specific proposal, called "Healthy Start," has been developed by the Illinois

Chapter of the American Academy of Pediatrics. It would help low-income families with uninsured children by providing outpatient services including preventive care, immunizations, developmental assessments, referrals and outpatient mental health services. Coverage would be based on a sliding scale for families with incomes of up to 250 percent of the federal poverty level. All families would pay a premium but no more than 5 percent of their income. Projections are that about 50,000 children, or one-third of those who would be eligible, would be enrolled.

According to the Illinois Department of

Public Health, this approach would cost about \$20 million with the state share at about \$13 million, or less than 2 percent of the annual revenue growth in Illinois.

Providing families with a primary health care home for their children is the most cost-effective means to quality health care. We can do no less for the vulnerable children of this state.

Dr. Rosenberg is a Barrington pediatrician and a member of ISMS' Governmental Affairs Council. He also chairs the Governmental Affairs Committee for the Illinois Chapter of the American Academy of Pediatrics.

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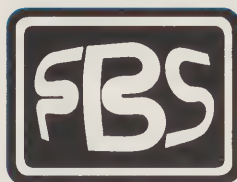
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ISMIE Update

Seminars give how-to's on documentation, communication

Loose lips, sloppy record-keeping can come back to haunt you.

BY CHRIS PETRAKOS

The demands of running a practice become more complex every year, requiring physicians and their office staff to have a firm grasp of administrative processes and strong communication skills. Some physicians and staff members who attended ISMIE's seminar "Risk Management: An Essential Office Practice" last fall said they learned the value of careful, complete record-keeping and effective communication with patients. The seminars, which will again be conducted beginning in March, cover such topics as communication skills, documentation, guidelines for record access and retention, patient follow-up, managed care issues and billing and collection procedures.

Specifically, one attendee said she learned which records should and should not be copied, maintained and released. Caroline J. Voderberg, practice manager for Neurological and Neurosurgical Associ-

ates Ltd. in Gurnee, said her office gets a lot of records from referring doctors, particularly prior to surgery. Her colleagues have been unsure about what should be photocopied and kept when they get requests for records.

*Special
authorization is
required for
particular records.*

"There was some confusion about whether we should copy all of a patient's records from another doctor," she said. Voderberg explained that when a practice gets a medical authorization or subpoena asking for "any and all" of a patient's records, the requester expects

that all records will be released. However, special authorization is required for particular records, such as those related to HIV, mental health, and drug and alcohol use, according to an ISMIE risk management specialist.

Several attendees said that information about the release of records, particularly those pertaining to HIV and mental health, impressed them. "We are very careful about the release of records," Voderberg said. "I've had insurance companies ask to audit secondary records, and I've told them they would have to inform their patients before we released the records. They were unwilling to do that, so the audits were not done."

If physicians don't feel comfortable releasing the records of other physicians, they should explain in writing why those documents weren't included, the specialist advised. "If we don't [copy the whole record] and the whole record is subpoe-



©William Campbell/Peter Arnold

naed, we're going to be asked why some records were left out," Voderberg said.

Equally as important as record-keeping is communication. Even some casual comments made by physicians and staff during conversation with patients can be construed as criticism of another physician or prior treatment, undermining the patient's confidence in that physician and the physician-patient relationship. Regardless of whether remarks are intended as criticism, they have the potential to cause patients to suspect that prior treatment didn't lead to the expected outcomes. That suspicion can even lead to lawyers and legal action. Seminar attendee John Rinehart, MD, a Glenview Ob/Gyn, said, "The speakers talk about those off-the-cuff comments that we all make that could come back to haunt a physician in court." A treating physician's criticism of prior care is one of the top underlying reasons for malpractice suits, according to ISMIE data. For all these reasons, it's important to be circumspect about what is said in front of patients.

Practices dominated by patients with complex needs often have more phone contact and consultations with those patients than do other practices, according to Gerald Sobel, MD, a Chicago internist. Regardless of the volume of phone contact, though, documenting clinically relevant telephone calls is critical, according to the risk management specialist. All calls

dealing with such issues as prescription refills, complications or concerns should be documented in the patient record. Elements to record are the time, date and purpose of the telephone call and the action taken or the advice offered. It's also helpful to develop office procedures that spell out which calls require immediate physician attention and which ones can be handled by a staff member, the specialist said.

Physician support on key issues like documentation is especially important, according to Voderberg, who said that the physicians in her office are intensely involved with staff education. That attitude makes a difference, she noted. "The doctors here are strongly committed to keeping up-to-date. I've attended four seminars in the last six months, and I pass on what I've learned during our practice meetings. The staff and the physicians value that."

Physicians and office staff who would like to attend one of ISMIE's upcoming office seminars will have an opportunity in many locations around the state starting in March and ending in November. For the first time, the half-day seminars will offer up to three hours of Category 1 credit toward the AMA Physician's Recognition Award.

The 1997 seminar will also look at issues related to the treatment of minors. For registration information, call the ISMIE Risk Management Division at (312) 782-2749 or (800) 782-4767, ext. 1327.

MALPRACTICE ROUNDUP

\$24 million awarded to boy who sustained brain damage after birth

A Cambridge, Mass., jury found two Boston physicians negligent after an infant sustained complications following the discovery of a congenital birth defect, according to the Feb. 10 issue of the National Law Journal.

In *Saluti vs. Rawn*, the baby was born in 1989 with the birth defect of congenital diaphragmatic hernia, which was considered serious but correctable. Six weeks after the surgery to correct the defect, the child's condition began to deteriorate. A physician was called in and ordered tests that were never completed. When the boy stopped producing urine and began showing signs of potassium overdose, a surgeon was called, but he sent an intensive care nurse in his place. The nurse "sedated him, making his condition worse and masking his symptoms," according to the plaintiff's attorney. The infant experienced cardiac arrest the next morning, and attending medical personnel stopped his potassium intake. He soon slipped into a coma and later sustained severe permanent brain damage.

The physicians' attorneys contended there was no potassium overdose and that the brain damage was an unavoidable complication of treatment for the birth defect. The jury found both physicians negligent but said the negligence of the physician whose tests weren't completed did not cause the brain damage. The surgeon was ordered to pay \$16 million to the plaintiffs. The physicians' post-trial motions to set aside the verdict were denied, and \$8 million in interest was added to the judgment. The decision has been appealed.

Illinois Supreme Court prepares to hear tort reform challenges

Trial lawyer group steps up opposition.

BY JANE ZENTMYER

With 17 tort reform cases on the Illinois Supreme Court's docket and more heading that way, court observers expected justices to consolidate all the cases and issue a single ruling on the constitutionality of the 1995 tort reform law. Instead, on Jan. 23, the Supreme Court chose to halt proceedings on all pending cases until it rules on a single product liability case from Madison County.

"What this means is that the court has chosen the Best vs. Taylor Manufacturing case, which came out of Madison County, as the vehicle for addressing these issues," said ISMS General Counsel Saul Morse. "It is not uncommon for one case to become the lead case when they have multiple lawsuits dealing with the same thing."

The Best suit stems from a Downstate forklift accident and didn't involve physicians or deal with medical malpractice. However, when Madison County Judge David Herndon ruled the entire 1995 tort reform law unconstitutional in August 1996, he also struck down the medical malpractice provisions.

With Herndon's ruling, the case headed directly to the state Supreme Court. "More disturbing than the failure to consolidate has been the court's position not to allow 'friends of the court' to offer expert opinions [in the Best case]," said Edward Murnane, president of the Illinois Civil Justice League, a coalition of organizations, including ISMS, that joined forces to support tort reform. "There are some outstanding constitutional scholars and lawyers in Illinois and elsewhere who are willing and prepared to offer their perspectives on the constitutionality of this legislation."

The ICJL and the Illinois Association of Defense Trial Counsel sought amicus curiae status in the Best case in the fall of 1996, but the Supreme Court denied the requests. With the Supreme Court's recent decision not to consolidate, both groups – along with ISMS, the Illinois Manufacturers' Association and the Illinois Hospital and HealthSystems Association – asked to file amicus briefs in the Best case. As of Feb. 4, however, all peti-

tions had been denied. No plaintiff attorneys have requested amicus status.

Morse said ISMS requested permission to file a brief in the Best case because the court records to be reviewed by the justices do not include physicians' views. "Nobody from the medical or health care community was involved at all, and we are concerned that

the whole statute was struck in the context of there being no argument, debate or exploration of the issues that deal with doctors, hospitals and their patients."

Someone will be arguing on behalf of tort reform, however. Illinois Attorney General Jim Ryan said he will use the office's constitutional right to be an "intervenor" in the case and will argue in favor of the tort reform law, according to Murnane. That brief is due in March.

The Supreme Court has accepted amicus briefs for other pending tort reform cases, including several consolidated cases from Cook County that are

known as the Gillis cases. ISMS was granted amicus status in those cases, which deal with medical malpractice issues. Those cases, however, are being held in abeyance until a decision is made in the Best case.

ISMS has filed an amicus brief in Kunkel vs. Walton, a case that addresses revisions to the Petrillo doctrine. The doctrine precludes defendant physicians

and their attorneys from ex parte communications with plaintiffs' former treating physicians unless the plaintiffs' attorneys are present or have agreed to the communication. The 1995 law modified the doctrine so that plaintiff attorneys are required to provide written consent authorizing the release of their clients' medical records within 28 days of requests. Failure to do so can result in a court order to obtain the records or dismissal of the case.

The Kunkel case was not included in those the Supreme Court decided to hold in abeyance, and it will proceed independently of Best and the other cases. What is unclear, Morse said, is the Supreme Court's timetable for the case. The court could hear oral arguments and/or issue its ruling on

(Continued on page 8)



Our case is stayed, but that doesn't mean we're staying.

Photo courtesy of Wm. Harte



— William Harte
Former ITLA
president

Illinois Supreme Court

(Continued from page 7)

Kunkel before or after ruling on the Best case.

The Supreme Court's decision not to consolidate the tort reform cases comes at a time when it faces problems of its own. One of the last acts of the Republican-controlled Illinois General Assembly was to send to Gov. Jim Edgar a plan to remap the districts from which the Supreme Court justices are elected. The redistricting would change the court's current 4-3 Democratic majority to a 4-3 Republican majority. Edgar had not signed the redistricting plan when this issue of Illinois Medicine went to press. The court also faced the governor's criticism of its ruling in the Baby Richard case and for the actions of some justices.

With the Supreme Court preparing to hear the tort reform cases, opponents of

tort reform are also gearing up. Well-known plaintiff attorney William Harte serves on the Illinois Trial Lawyers Association's Constitutional Challenge Committee, which is working to end tort reform. Harte is also a former ITLA president and has more than 20 years of experience fighting tort reform beginning with his opposition to ISMS' tort reform efforts in 1975. Ten years later, Harte led the anti-tort reform efforts as chief negotiator for Speaker of the House Michael Madigan (D-Chicago).

Harte filed the motion to consolidate all pending tort reform cases before the Supreme Court and indicated in the motion that he would file a single brief on behalf of all plaintiffs and would coordinate the oral argument. Harte said he wasn't surprised by the Supreme Court's decision, adding that ITLA awaits Ryan's filing of his brief.

During the summer of 1996, ITLA

imposed a mandatory one-time assessment on its members to raise funds to contribute to the group's fight against tort reform, according to ITLA President Geoffrey Gifford. Members were responsible for paying sums equaling their annual dues, which range from \$150 to more than \$1,000. Members who don't contribute will be forced out of the organization, Gifford said. So far, about 3 percent of the association's 2,500 members have failed to pay.

"This organization made the decision that everything was on the line and people who were members either had to put up or shut up," Gifford said. He did not say how much money was collected. "Depending on how long this battle goes and how far it goes, it may very well be that we'll have to go back, not to the membership, but to the main firms that have always supported us and ask for some additional contributions."

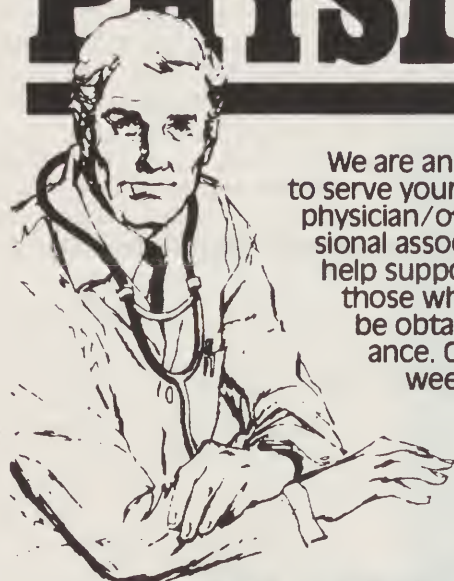
The assessment will be used to fund only the tort reform court battle, not the lawyers representing the plaintiffs in the cases, Gifford said. The money goes toward such legal expenses as paying librarians to do research and expert counsel to help with the constitutional aspects of the case.

Gifford added that in the future, ITLA will need to win on two fronts: "We have to win in the Supreme Court, but we also have to keep control of one house of the Legislature, or else, obviously, this could have to be done over again."

Harte summarized ITLA's current plan of action: "Our case is stayed, but that doesn't mean we're staying."

ISMS President Sandra Olson, MD, explained the Society's perspective: "We spent 20 years fighting for the 1995 tort reform law, and we knew that maintaining our ground wouldn't be easy. We won't be dropping out of the fight now." ■

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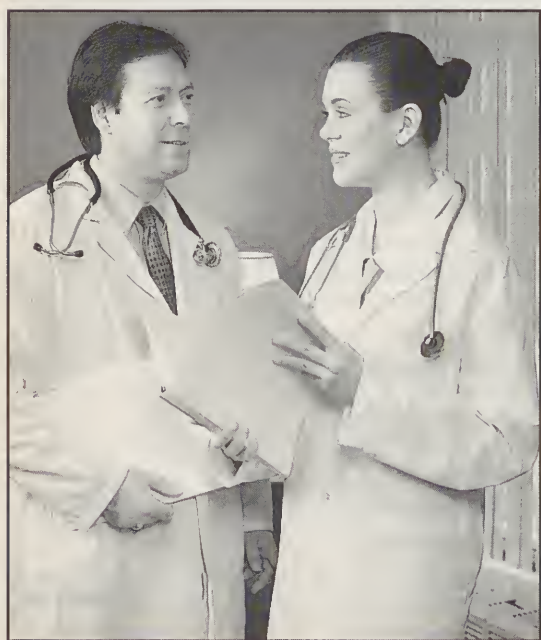
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MCPRA aims

(Continued from page 1)

bership would have to include at least 25 physicians, with no more than 20 percent of the membership from any one medical specialty. The boards would recommend medical policies to the plans' governing boards, which could accept or reject them.

"An independent medical staff is the only mechanism of which I'm aware that would leave physicians in charge of clinical decision-making and peer review," said Craig Backs, MD, a member of the ISMS Governmental Affairs Council and president of the Illinois Society of Internal Medicine. "We have a long-standing history of independent medical staffs in the hospital setting. Self-governance of the medical staff limits the ability of the hospital administration to control physicians and clinical decision-making. [MCPRA] would set up a similar type of structure and level of protection."

Under MCPRA, physicians would recommend to the plans' governing bodies the necessary length of hospital stays for various procedures. The plans would then accept the medical review board recommendations or work with the board on compromises.

The medical staffs would credential participating physicians. After evaluating physicians' credentials based on the medical staffs' criteria and the law, the staffs would recommend physicians to the governing bodies, which would have the final say on medical staff membership and privilege decisions.

Many managed care plans can now cancel or not renew contracts with physicians who do not meet their requirements for clinical decisions, Dr. Backs explained. Creating independent medical staffs would mean that if physicians chose in good faith, on their patients' behalf, not to follow the plans' requirements, those doctors would be reviewed by peers with similar clinical decision-making experience.

Dr. Backs said that the independent medical staffs would raise "a substantial division between the business of the managed care organization, which is to make money, and the clinical activities of the physicians on the medical staff, which is to care for patients."

ISMS House of Delegates' positions and policies formed the basis for this and other provisions of MCPRA. ■

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Illinois physicians opt

(Continued from page 1)

Dr. Brusca signed up for his MSA through the Physicians' Benefits Trust, which is a cooperative effort between ISMS and the Chicago Medical Society that provides a range of insurance plans to meet the needs of physicians, their families and their employees. "One of the reasons that anyone would want it is that the contributions that they make to it are tax deductible," Matthews said. "The contributions can be maintained tax free for an indefinite period as long as they are in a medical savings account."

Most physicians, whether they practice in groups or as individuals, can qualify for MSAs because the accounts are currently available to businesses with fewer than 50 employees. The number of MSAs permitted during the test period outlined in the Kassebaum-Kennedy legislation, which ends in 1999, is limited to 750,000. At that point, Congress will re-evaluate the program and consider expanding it.

"Many people have the impression that the money that goes into the account comes out of funds that they're currently living on," said Robert Hamilton, MD, ISMS Sixth District trustee. "This money comes out of the compensation they already received in the form of low-deductible insurance. It's the difference between the cost of a low-deductible and a high-deductible premium that makes money available to put into this account."

"High-deductible" is defined as a \$1,500 minimum and \$2,250 maximum for individuals, according to PBT. The law limits the annual contribution to 65 percent of the deductible, or between \$975 and \$1,462. Deductibles for families can range from \$3,000 to \$4,500. Annually, families may contribute up to 75 percent of those deductibles, or from \$2,250 to \$3,375.

MSAs can be worth a significant amount of money over time. Consider a 25-year-old or his or her employer who places the minimum amount allowed by law, \$975 annually, into an MSA. Assuming no medical expenses and an 8 percent return on the investment, that employee would have \$6,177 in the account after five years, \$76,980 after 25 years and \$272,786 after 40 years.

Before signing up for an MSA, physicians and others should understand how they work, Dr. Hamilton said. The law's definition of medical expenses may not be the same as the health plan's. That may make a difference in calculating the contribution toward the higher deductible.

Besides the tax advantages, MSAs also offer the flexibility for patients to choose the services and physicians they want while weighing the costs of the services provided. Opponents have argued, however, that these accounts will reduce preventive care because account holders will forgo health care in favor of earning money – a criticism Dr. Hamilton disputed.

"People who are discriminating enough to want to get into a medical savings account program are also going to be discriminating enough to know that if they take care of something while it's relatively minor, it costs a lot less money than if they allow all kinds of complications to develop," he said. Physicians who want more information about starting an MSA may call the Physicians' Benefits Trust at (800) 621-0748. ■

Hines VA to streamline

(Continued from page 1)

Here's how the telepathology system works: A microscope is coupled with a digital camera at Iron Mountain. Pathologists at Hines and Milwaukee can operate the microscope via computer, using either a mouse or a small keyboard. "We can change the X- and Y-axes, the focus, the lighting and the magnification, all by using a computer," said Dr. Dunn. "There's less than two-tenths-of-a-second delay between what happens [in Iron Mountain] and what happens [in Milwaukee]." When the consulting

pathologists locate an area they want to examine more closely, they can take static images with higher resolutions than the real-time, he added. So the pathologists are able to see an entire slide and control images as needed.

Iron Mountain's VA center no longer has diagnostic physicians on site; pathology, radiology and nuclear medicine imaging have been fused into one clinical cluster overseen by Dr. Dunn in Milwaukee. Instead, the clinicians in Iron Mountain use telemedicine to provide the appropriate diagnostic services.

With Hines hooked into the system, the information-sharing capabilities


should expand, Dr. Chejfec predicted. "We have a group of pathologists here representing a wide variety of subspecialty expertise. Now we should be able to provide valuable consultation in both archival and real-time fashion."

As of late January, all the necessary equipment was functional and in place at Hines, Dr. Chejfec said. The final hurdle was shifting from a T-1 telecommunications line to an integrated services digital network line, allowing for even quicker and better image access, he said.

The development of telemedicine technology in Illinois is supported by ISMS' House of Delegates. ■


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Physicians and lawyers find common ground

PAGE 9

Illinois Medicine

ILLINOIS STATE MEDICAL SOCIETY • MARCH 14 1997

HCFA requires
stop-loss coverage
for some
physicians, groups

PAGE 7

House panel hears managed care testimony

INPUT: ISMS president, internist and family physician are among those discussing the pros and cons. BY JANE ZENTMYER

[SPRINGFIELD] Illinois legislators tackled managed care reform at a Feb. 18 hearing in Springfield conducted by the House Committee on Health Care Availability and Access. Through an upcoming series of hearings, reform proponents

and opponents will offer their perspectives to lawmakers who will in turn craft legislation.

Testifying at the hearing was ISMS President Sandra Olson, MD, who discussed the pluses and minuses of managed care: "Managed care has changed the way doctors do their jobs and the way patients get their care. And it's done a lot of good helping all of us to regain some control over the growing cost of health care. We must recognize it is here to stay, and it will be a part of our future. But that doesn't mean it can't work better.

"TV, newspapers and magazines have told us about cases where medical care was delayed or denied with tragic results," Dr. Olson continued. "Just about every doctor I know has discovered plenty of interfer-

ence into the patient-doctor relationship that is not quite dramatic enough to make national news, often thanks to the doctor's efforts in the role of patient advocate."

Dr. Olson characterized the health care rights that all Illinois patients deserve as "quality, choice, individual respect, advocacy and information." To help ensure those rights, ISMS developed the Managed Care Patient Rights Act, which was introduced in 1996 and "refined and improved" for reintroduction this year as H.B. 603 and S.B. 705, she said.

In addition to Dr. Olson, others testifying included representatives of consumer groups, managed care plans and the Illinois Nurses Association. (Continued on page 14)



PRESIDENT OF THE ILLINOIS SOCIETY of Internal Medicine Craig Backs, MD, and ISMS President Sandra Olson, MD, talk to state lawmakers about the need for passage of the Managed Care Patient Rights Act at a Feb. 18 hearing in Springfield.



Ron Ackerman

Coalition, physicians push state mental health parity

REFORM: Group says coverage of serious mental illness has little effect on premiums. BY JANE ZENTMYER

[CHICAGO] David and John work at the same company, carry the same insurance and have incurable but controllable illnesses. David has diabetes, and John has bipolar disorder. Both illnesses require expensive medication, constant monitoring and occasional hospitalization.

"But the parallels end there," said Linda Virgil, president of the Alliance for the Mentally Ill-Illinois. David's insurance coverage provides a \$1 million lifetime cap for diabetes, a \$100,000 annual limit and a 20 percent co-payment. John's coverage with the same company for bipolar disorder provides a \$25,000 lifetime cap, a \$2,000 annual cap and a 50 percent co-payment. "This is discrimination," she said.

Virgil joined legislators and fellow members of the Illinois Coalition to Stop Insurance Redlining of Mental Illness at a

news conference in Chicago on Feb. 10 to announce the introduction of H.B. 111. The measure requires insurance companies to cover mental illnesses under the same terms as other illnesses. ISMS supports the bill.

"The ancient ideas that somehow severe mental illnesses were caused by how you were raised by your mother [or] by faulty toilet training simply don't hold scientific water," said Valerie Raskin, MD, president-elect of the Illinois Psychiatric Society. "There is no medical justification to insure illnesses like diabetes or epilepsy and refuse or diminish coverage for mental illnesses."

Although the Kassebaum-Kennedy legislation that passed last year includes some mental health parity provisions, state legislation will help fill in some of the gaps in the federal law.

(Continued on page 15)

INSIDE

Illinois legalized marijuana for research in 1978

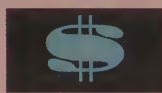


PAGE 3

Merger of Illinois, Texas Blues fits with national trend

PAGE 6

Gov. Edgar earmarks extra \$6 million for AIDS drugs



PAGE 8

DEPARTMENTS

Commentary.....4

Malpractice Roundup.....7

IDPR Disciplines10

Classifieds11

Medicare focuses on attending physicians' supervision of nursing home residents

ANTI-FRAUD: HCFA focuses on prevention.

BY CHRIS PETRAKOS

[CHICAGO] State implementation of a federal initiative to crack down on Medicare abuse in nursing facilities begins March 15, according to the Health Care Service Corp., which administers Medicare Part B in Illinois, according to information from HCSC.

"It really goes back to Operation Restore Trust," said Douglas Busby, MD, HCSC's medical director of Medicare (Illinois), referring to the Health Care Financing Administration's anti-fraud initiative. "This is all part of the government's attempt to get utilization in nursing homes to a reasonable level, focusing on medical necessity."

HCSC will cover services or procedures performed on residents of skilled nursing facilities or nursing facilities only under one of two conditions. The first is that the attending physician must evaluate the resident and

authorize the order for the service or procedure or for referral to a "provider specialty" such as audiology, optometry, podiatry, psychology, psychiatry, physical therapy and occupational therapy. The second condition is that a named physician requested by the resident or resident's family must evaluate the resident and authorize the order for the service or procedure. In the latter case, the attending physician must be notified of any change in the resident's physical, mental or psychosocial status or the need to change treatment significantly. The requirements apply to standing orders for all provider specialties and for all routine screenings regardless of where the order is written, according to HCSC.

In addition, every resident of a skilled nursing facility or nursing facility must undergo (Continued on page 13)

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ILLINOIS SECRETARY of State George Ryan announces Feb. 11 in Chicago his legislative proposal for an automatic 30-day driver's license suspension for anyone who misuses or fraudulently obtains a disabled parking placard or license plate.



John McNulty

State grants boost medical care in underserved areas

[SPRINGFIELD] The Illinois Department of Public Health awarded \$1.2 million in Rural/Downstate Health Act grants to nine new recipients this year.

The grant program was designed to improve access to primary care services in rural and underserved parts of the state. Recipients may apply for continued funding for up to six years. The selections were made by representatives of ISMS, the Illinois Academy of Family Physicians, the Illinois Hospital and HealthSystems Association, the Illinois Farm Bureau, Southern Illinois University and its School of Medicine, the University of Illinois and Western Illinois University. Lawrence Jennings, MD, of Mount Carmel, represented ISMS in the selection process.

Many of the grants are designed to curb patient travel time by increasing services in patients' communities. Mary Ring, chief of IDPH's Center for Rural Health, said, "Whenever patients leave the area, the community loses those health care dollars. And if the patients are in longer-term health care, they could end up finding a primary care physician in the urban area, so these grants try to slow some of the rural 'outmigration.'"

Nearly \$410,000 has been allocated to five hospitals in designated "medical shortage" areas. Hardin County General Hospital will develop restorative and rehabilitation services as well as a physical

therapy department. Mercer County Hospital in Aledo will establish a telemedicine link with St. Francis Medical Center in Peoria. John and Mary E. Kirby Hospital in Monticello will create a certified rural health clinic in eastern DeWitt County and install satellite units in three rural clinics and in the Piatt County Mental Health Center to expand the telemedicine system. The Harrisburg Medical Center and Galeana-Strauss Hospital in Galena will use their grants for existing programs.

Almost \$399,000 was split among eight community-based primary care centers including three new projects. The Wabash County Health Department in Mount Carmel will start a rural health clinic to improve access for the area's Medicaid and Medicare patients. The Macoupin County Public Health Department in Carlinville will create three public health centers in the existing clinic's facilities. The department plans to offer health screening, mental health counseling and educational programs. Community Memorial Hospital in Monmouth will purchase telemedicine equipment to reduce travel for radiology patients.

Seven community health centers, including three Chicago-area sites, divvied up \$409,010. The new recipients include Roseland Christian Health Ministries in Chicago, Rural Health Inc. in Anna and the Lake County Health Department in Waukegan. ■

Group works to reduce cesarean sections

[CHICAGO] A new brochure developed by the Cesarean Section Appropriateness Collaborative – a coalition of employers, health plans, hospitals and physicians formed by the Midwest Business Group on Health – aims to educate women about the benefits of vaginal births after cesarean sections.

About 70 percent of women can successfully deliver vaginally after a previous cesarean birth, according to the MBGH. Subsequent vaginal deliveries are safer because of lower, horizontal incisions used in cesareans.

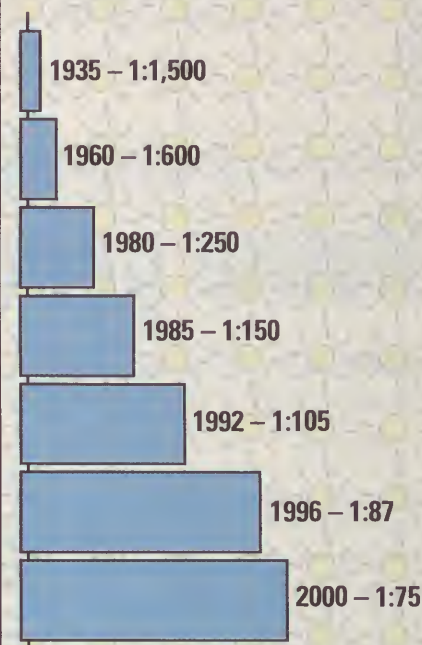
The coalition "gives us the opportunity to communicate with others who share our objective and to work with them to identify and develop tools for improvement, which we can use in our own business," said William Rollow, MD, medical director of BlueChoice, Blue Cross and Blue Shield of Illinois' point-of-service plan. "It allows us to link our activities to a community-wide effort, which has greater impact than we can have alone."

The brochures were mailed to Ob/Gyns and primary care physicians in the Chicago area. Copies are available upon request. For more information, call Matt Schuller at (800) 552-0556. ■

The risk of rays



Lifetime risk of developing melanoma in the United States, 1935-96, projected to 2000



Source: American Cancer Society

State taxpayers can contribute to Alzheimer's, cancer research funds through IL-1040

[SPRINGFIELD] Illinois taxpayers again have the opportunity to contribute part of their state tax payments to the Alzheimer's Disease Research Fund and the Breast and Cervical Cancer Research Fund.

These two fund "checkoffs," overseen by the Illinois Department of Public Health, are among five that appear on the 1996 IL-1040 income tax forms. Other causes include funds for wildlife preservation, child abuse prevention and assistance to the homeless.

The Alzheimer's Disease Research Fund checkoff has been part of the tax form for 11 years, raising more than \$1.5 million for some 73 research studies, according to IDPH. The Breast and Cervical Cancer Research Fund has been part of the tax form since 1994 and has raised a total of about \$358,000 to fund 21 research grants. Donations to both funds will be earmarked for research, prevention, early detection and treatment, with no money used for administrative costs, according to IDPH.

Funds must collect at least \$100,000 each year to reappear on the next year's tax form. One fund, to help establish a women's military memorial, failed to collect the minimum donations and is not an option among the checkoffs offered this year.

Since the contribution program began 11 years ago, donations hit an all-time high of \$1.97 million in 1989 and dropped to about \$811,000 in 1996, according to the Illinois Department of Revenue. This is the first year since the checkoffs began that the Illinois General Assembly has not added a contribution option. Fewer than 50,000 Illinois taxpayers contributed through the checkoffs last year, representing less than 1 percent of the total number of taxpayers in the state. ■



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Correction

In the Feb. 14 issue, a photo caption on page 1 incorrectly identified Illinois Rep. David Phelps (D-Harrisburg) as Speaker of the House Michael Madigan (D-Chicago). We regret the error.

1978 Illinois law legalized marijuana for research purposes

CANNABIS: Legislation was designed to help patients with glaucoma, cancer. BY JANE ZENTMYER

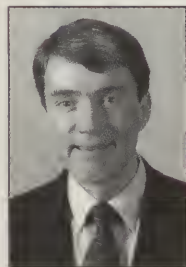
[CHICAGO] Officials with the Illinois Department of Alcoholism and Substance Abuse were as surprised as other Illinoisans to learn that a 1978 law still allows marijuana to be used legally for specific medical research purposes.

"Nothing ever really came of it because the different state departments involved, like DASA and the state police, don't really have a mechanism for operating the program," said DASA spokesperson Tom Green. "People who were not involved in state government in 1978 were somewhat surprised to find out that this law was still on the books."

The law allows DASA, with the written approval of the Illinois State Police, to authorize the production, manufacture and delivery of substances containing cannabis for research use. Physicians who meet research protocols can prescribe marijuana to treat glaucoma and the side effects of chemotherapy or radiation therapy, and to conduct other medical procedures. Authorized individuals are exempt from prosecution in Illinois for the possession, production, manufacture and delivery of marijuana.

Green said that no physician has ever asked to prescribe marijuana under this law, and many of the procedures and protocols the law requires for implementation no longer exist. The issue is now under review, he added.

DASA and ISMS "have chosen to wait on further review of research currently being undertaken at the AMA and the



Dr. Doot

Institute of Medicine before changing any policies on the medical uses of marijuana," said DASA Medical Director Martin Doot, MD, in a statement. "We believe that research of this type should be done with extreme caution

and with all the necessary safeguards in order to carefully weigh the potential risks and benefits not only to an individual patient but to society in Illinois."

Dr. Doot cited concerns about the addictive nature of cannabis and the possible effect of changes in public perception. Efforts to downplay the potential for addiction can be directly tied to increased marijuana use among adolescents, he said.

DASA's current administrative code does not include standards for licensing

researchers and such projects as cannabis-related research, Green said. DASA decided not to license this type of activity after staff cutbacks and a review of the department's licensing authority in August 1994. As a result, all researchers under DASA's jurisdiction withdrew or

failed to renew their licenses.

According to DASA records, the department never licensed researchers whose projects included using marijuana on humans. Most of the licenses were granted for animal research, classroom demonstrations and canine and personnel training by law enforcement agencies.

The 1978 law was sponsored by former Rep. Joseph Ebbesen (R-DeKalb), an optometrist, and former Sen. John Grotberg (R-St. Charles), then a cancer patient. The House and Senate approved the bill with little dissent. When then-Gov. James Thompson signed the bill, he

said that it was not a step toward legalization of cannabis, according to 1978 news reports.

The latest nationwide controversy about the legalization of marijuana began when voters in two states – Arizona and California – approved referendums in November 1996 that allow the use of cannabis for medical purposes. In response to the new state laws, federal officials have issued warnings that they plan to revoke the DEA registrations of physicians who prescribe marijuana and to exclude those doctors from participating in Medicare and Medicaid programs, according to news reports. ■



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REPORT for Illinois Physicians

Billing for a Surgical Procedure in an Office Setting

When a physician performs an outpatient, surgical procedure in his or her office, materials and supplies should not be billed for separately. Surgery related materials and supplies for these procedures are included in the allowance for the procedure. Materials and supplies provided by the physician which are over and above those usually included with the service rendered should be billed with a 99070 CPT procedure code. Conversely, when the same procedure is performed in a facility setting, the professional allowance for this procedure does not include costs related to surgical materials and supplies.

Blue Cross and Blue Shield of Illinois provides facility benefits to its members only when the outpatient surgery is performed in either an Illinois licensed ambulatory surgery center (ASC) or hospital. Accreditation of an ASC by the State of Illinois ASC licensing agency qualifies the center for reimbursement by Blue Cross and Blue Shield of Illinois as an ASC.

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EDITORIAL

Gag practices

There's more than one way to gag a doctor. By now, everyone has heard of contractual gag rules, whereby some managed care plans explicitly prohibit physicians from talking to patients about treatment options that aren't covered by the plan. But some plan practices that aren't spelled out in contracts may indirectly keep physicians from communicating openly with their patients or from fully advocating for their patients. That's one reason ISMS developed the Managed Care Patient Rights Act, which was introduced into the General Assembly last month.

The act is based on the premise that patients must have confidence that their doctor is working as their advocate. Toward that end, MCPRA bans the use of contractual gag clauses and establishes as public policy that physicians should advocate for medically appropriate health care for their patients. It forbids managed care plans' retaliation against doctors for that advocacy.

Full and open patient communication requires that patients be notified in a timely way if their coverage or their doctors' participation in a plan is terminated. Physicians who speak out on their patients' behalf and as a result, face unilateral termination by plans need the protection provided by due process. MCPRA establishes due process procedures, so plans that terminate physicians must document and confirm the reason and must provide for a panel of physicians to hear the case. If pay-

ment for service is denied, patients need to know who was responsible for the decision, how to contact that individual and how to appeal the decision. MCPRA creates a standardized appeals process for patients—a critical anti-gag remedy.

After more than 200 bills addressing managed care problems were introduced into the General Assembly this session, the Illinois Association of HMOs was forced to acknowledge some of those problems by developing a bill that is now being considered by lawmakers. ISMS is reviewing the measure to see how it stacks up to MCPRA in ensuring effective protections for patients. An AMA lawyer expressed skepticism about managed care industry reforms in general, though, saying that insurers have been "virtually forced to take a more pro-patient position" to address consumers' concerns and fend off state and federal legislation, according to the New York Times.

The disclosure issue is also getting federal attention. On Feb. 20, President Bill Clinton announced that health plans that serve Medicaid patients may not use gag rules. The AMA commended the president's action and supports the patients' rights act introduced into the U.S. House by Reps. Greg Ganske (R-Iowa) and Ed Markey (D-Mass.). In fact, the AMA is working on a companion Senate bill.

Insidious gag practices are as threatening as overt gag rules. MCPRA gives the entire communication issue the attention it deserves.

PRESIDENT'S LETTER

Allies forever

Sandra F. Olson, MD



What other group do you know that exists only to work – without pay – for our projects and patients?

I want to take this opportunity to shine the spotlight on a group of people who work tirelessly, often behind the scenes and without fanfare, to support the various programs of ISMS. You guessed it! Our Alliance – the spouses who spend time, money and their efforts to champion and extend our social and political causes for the benefit of our patients. I'd like to introduce the principal players – Mrs. Kathy Kelley of Mount Vernon, who is the current president and whom I've had a chance to see and visit with recently, and Mrs. Julie Ringhofer of Belleville, president-elect. The published purpose of the Alliance is "an organization of physician spouses whose purpose is to help the medical profession in its endeavors to improve the health and quality of life for all the citizens of Illinois." I am very proud to tell you that my spouse, Ron, has been a member for years. In fact, he's gone on some of the tours at various meetings and is known as "the unofficial photographer" of the group.

The ISMSA was organized 70 years by Mrs. Henry Mundt. Its present membership is 2,500. In keeping with its stated mission, the Alliance has sponsored many programs that have helped both our patients and our members in furthering our objectives. I'd like to recap some of them.

One of the most effective and influential current programs is the mini-internship, sponsored in partnership with county medical societies. This experience gives legislatures, community leaders and others the chance to spend a day with a doctor and see firsthand what we do and how we function in our daily practice routine. I've had the opportunity to talk to some graduates of this program, and they have found it informative, stimulating and rewarding. They also say they have a greater sense of our day-to-day functioning and responsibilities and better appreciate our patient care activities.

The Alliance works to further our legislative agenda by keeping its members informed on issues and encouraging them to support

our efforts in that arena. The Alliance supports our student loan fund, which provides financial assistance to medical students, and our benevolence fund, which supports and assists physicians and their families in the event of tragic circumstances, illness or both.

ISMSA DEVELOPED the Medi-Card – a free wallet-sized card on which senior citizens can list their medicines and other important related information. They developed the "Sick-Days" pamphlet to aid parents in deciding if a child is truly ill and should stay home from school.

Last but not least is the aggressive campaign against domestic violence, which has become a prime target of the Alliance's efforts in recent years. Programs in this project on violence have been created to help physicians identify the signs of family abuse and provide educational materials to better serve their patients. This packet of information, available to all physicians through ISMS, also includes a CME presentation on treatment protocols, which provides two hours of Category I credit. In the packet, physicians can find resources specific to Illinois and information from the AMA on joining the National Coalition of Physicians Against Family Violence, a tremendous collection of additional material, all at no charge. With the recent report from the Chicago Department of Public Health that lists violence as the No. 1 public health hazard for women, this program has never been more timely, and it is of great potential benefit to patients and physicians in Illinois alike. If you haven't already received your information, please call ISMS, and we'll make sure that you get all the background material you need.

You see how active and effective our spouses have been and continue to be. What other group do you know that exists only to work – without pay – for our projects and patients? Let's give them a big round of applause.

GUEST EDITORIAL

Managed Care Patient Rights Act offers hope to patients

By Nicholas Vogelzang, MD

I am treating a 63-year-old patient with malignant mesothelioma. The challenges she faces with her managed health care plan have been nearly as severe as those related to her illness, and they could be resolved with the passage of the 1997 Managed Care Patient Rights Act.

Because I, as her oncologist, must seek approval from her primary care physician for each stage of her complicated treatment, I have seen valuable

time tick away when treatment could have been administered. And I have seen a patient, already overwhelmed

by the severity of her disease and the necessary care, become frightened that the plan may deny her treatment. This is not fair to her.

MCPRA would allow my patient — because of her chronic condition — to choose me as her principal care physician, thus averting the required and often cumbersome referral process for each stage of her oncological treatment.

The patient I've described was initially referred to me so that I could administer an investigational drug, which successfully controlled the symptoms of her cancer for more than two years. The growth of her tumor was minimal but real, so that drug therapy was discontinued, and we needed to move to the next phase.

To do that, we needed the approval of the patient's primary care physician, who had seen her two to three times a year. Oncologists at the University of Chicago Hospitals, however, had seen her weekly or biweekly for two years. The managed health care plan required the primary care provider's approval despite his lack of expertise in managing this type of cancer and his unfamiliarity with her current health status. The approval process took nearly three months at a point when timing was critical.

When the second treatment didn't work, the patient wanted to proceed to the next treatment phase — standard chemotherapy. That treatment was also

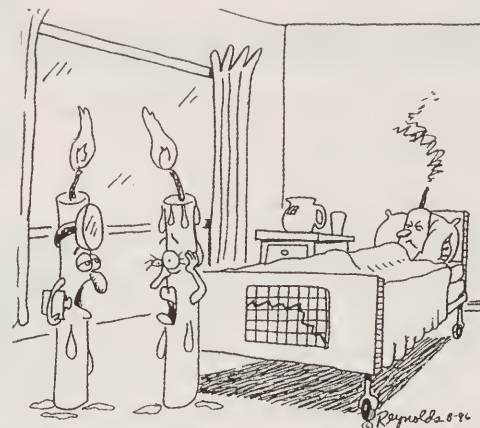
questioned extensively by the plan, again delaying treatment.

In this situation, the oncologist is, and must act as, the principal care physician. A disease as complicated and as chronic as cancer requires an oncologist as a principal care physician. This patient identifies me as her principal caregiver. She and her family seek my opinion regarding her disease, and her life revolves around battling cancer. Fortunately, the patient's general health is excellent, with no other intervening illness. So, it makes perfect sense that she and others like her should have access to oncologists and other appropriate specialists as their principal care physician.

My patient is now undergoing another type of chemotherapy and is still having difficulties with her managed care plan. On every visit, she tells me she is afraid that her plan will disallow her to continue getting oncological care because of cost and a lack of understanding of the need for it. Is that a real possibility for patients like her? I don't know. But it's an important perception.

Under MCPRA, managed care plans would create independent medical staffs, which would provide significant input into plan policies and clinical procedures. The arrangement would put more control into the hands of the physicians who know and understand the needs of their patients. Increased physician input would allow for more flexibility in treatment.

As physicians, we provide patients with freedom in the form of hope, which is rooted in the Judeo-Christian ethic on which our country was founded. This freedom and hope are as firmly rooted in



"I'm afraid your husband has suffered a terrible blow to the head."

the United States as mom, apple pie and the pursuit of happiness. The access to new drugs, new science and new technology provides hope that is almost a right, and we do not want to inhibit our patients' ability to reach that hope. The American people and the American psyche demand it.

Some patients will look everywhere for a given treatment, but many will not, accepting fate and realizing the constraints of their own resources and their plans' bureaucracy. But even those who accept those constraints have a right to know their options.

We need legislation to guarantee that patients have access to the best health care possible regardless of the setting. Because my patient's managed care plan failed to approve her treatments in a timely way, she may have ultimately been failed by our profession. Patients who have chronic conditions and face complex treatments should be able to select a principal care physician. The 1997 Managed Care Patient Rights Act is imperative for our patients.

Dr. Vogelzang is an oncologist at the University of Chicago Hospitals and past president of the Illinois Chapter of the American Cancer Society.



Fliers for patients available free

Physicians can get free, ready-to-use fliers dealing with health care, including preventive medicine, to give to their patients. The fliers, called "Your Health Matters," deal with a variety of topics and are distributed monthly to the Illinois media. They're developed by ISMS' Council on Public Relations and Membership Services and ISMS members.

Recent topics have included medical savings accounts (see insert on this page), a new state law allowing women direct access to their obstetrician or gynecologist, Alzheimer's disease, holiday depression, hypothermia and treatment for the flu.

The media use the fliers as a source of health tips for readers and as background information for radio or television interviews.

Members interested in getting a supply of past, current or future editions of "Your Health Matters" should contact ISMS' Public Relations Department at (800) 782-ISMS or (312) 782-1654.



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Texas and Illinois Blues' merger part of trend

CHALLENGES: Lawsuits allege conflict with state law regarding nonprofit status. BY JANE ZENTMYER

[CHICAGO] Blue Cross and Blue Shield, like other insurers, has joined a nationwide trend of mergers that seek to end duplication and save money. Since 1976, the number of Blues plans across the nation has dropped by half, to 61, mostly the result of mergers, said Iris Shaffer, spokesperson for the Chicago-based Blue Cross and Blue Shield Association. About a dozen mergers are pend-

ing, she said.

Merger fever is facing some legal challenges, however, primarily based on charges that nonprofit companies are being acquired by for-profit organizations or converting to for-profit status. Blue Cross and Blue Shield of Missouri and the state of Missouri are engaged in a lawsuit stemming from the state's demands that the health plan pay up to

\$500 million for converting almost entirely to for-profit status.

After Blue Cross of California's conversion to for-profit status, the insurer paid \$3 billion in assets to the state – the largest health-related donation in California's history – to create two charitable foundations.

The Ohio attorney general filed suit last July asking to be appointed to redistribute the assets of Blue Cross and Blue Shield of Ohio to charitable organizations following the announcement of a \$229.5 million deal that would transfer the Blues plan's assets to the for-profit Columbia/HCA Healthcare Corp.

Illinois is also involved. Texas Attorney General Dan Morales filed a lawsuit last November to block the proposed merger between Blue Cross and Blue Shield of Illinois and Blue Cross and Blue Shield of Texas. The suit asks the court to find that the merger violates Texas law and asks for damages to be awarded because the board of the Texas Blues breached its fiduciary duty by agreeing to an illegal merger. Also, if the Texas Department of Insurance approves the merger proposal, the suit asks the court to stop the merger.

"This suit is about simple fairness," Morales said. "Blue Cross and Blue Shield's assets belong to the people of Texas. If it wants to merge with another entity, it must do so in strict accordance with state law. This proposed deal does not appear to meet that test."

Texas state law specifies the kind of companies that can merge with an organization like the Texas Blues, according to the suit, which was filed against the insurer and 12 of its for-profit subsidiaries and affiliates. BCBST was incorporated in 1939 as a "charitable and benevolent, nonprofit hospital service plan corporation," according to the suit. The law allows a merger of a Texas nonprofit company and an out-of-state corporation, which is defined as a nonprofit entity that prohibits the distribution of its income to its members, directors or officers. The suit claims that BCBSI doesn't meet that requirement.

*This suit is about
simple fairness.*

The Illinois insurer's articles and bylaws characterize it as a nonprofit organization. But the suit alleges that the company is organized as a mutual insurance company, which isn't required by Illinois law to continue operating as a nonprofit company. BCBSI's articles and bylaws can be changed at any time by a majority vote of its board of directors. The merger would move the Texas carrier's "charitable" assets to Illinois and subject them to Illinois law, according to the suit.

"We would not have entered into this transaction with the Illinois plan if we were not confident that it was permissible under both Texas and Illinois law," said Mike Doll, a spokesperson for BCBST. "We are confident that our position will prevail in court as well. Blue Cross and Blue Shield of Texas is firmly committed to the position that the merger is in the best interest of our organization and the people of Texas whom we service."

Because the suit is pending, BCBST declined to comment on any details of the suit. A BCBSI spokesperson referred all questions about the lawsuit to the Texas Blues.

The two plans took the first step when they reached an affiliation agreement in late January 1996. The combined revenues are estimated at almost \$6 billion, which would make the merged company the second-largest Blues in the nation. BCBSI has annual revenues of \$4.1 billion, and BCBST pulls in \$1.6 billion. Total insureds would be 3.8 million.

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ISMIE Update

HCFA requires stop-loss insurance for some physicians, group practices

COVERAGE: A new regulation applies to cases of "substantial financial risk."

BY CHRIS PETRAKOS

[WASHINGTON] The U.S. Health Care Financing Administration now requires stop-loss insurance to be in place for physicians and physician groups that are at "substantial financial risk" for the types of treatments sought by their managed care patients who are enrolled in Medicare or Medicaid. The new rules went into effect Jan. 1, nearly a year after HCFA began soliciting public comments on the regulations.

Substantial financial risk exists when 25 percent of a physician's or physician group's potential income is at risk for referral services that the physician orders but does not provide, according to HCFA. If a physician group has more than 25,000 patients, the group and its participating physicians are not considered to be at substantial financial risk because the risk is spread over a large patient base. These 25,000 patients may be enrolled in Medicare or Medicaid or affiliated with private managed care plans, according to HCFA.

Harold Jensen, MD, chairman of the ISMIE Board of Gov-

ernors, explained why stop-loss insurance is necessary: "Let's say a physician has signed up with a capitated system. He or she has 100 patients, and one of them needs a bone marrow transplant. The costs of treating that patient could chew into capitation funds so severely that he or she might see the other 99 patients for nothing for the rest of the year. So the stop-loss insurance would put a ceiling on the doctor's losses." Dr. Jensen added that ISMIE anticipated such contingencies last year when it added Physician Provider Stop-Loss insurance to its Seamless Coverage comprehensive professional liability offerings.

PAYMENT FOR the stop-loss coverage required by HCFA has been the subject of debate. The original draft of the regulation stated that managed care plans must provide stop-loss insurance to physicians, or if stop-loss insurance was already in place, the plans must pay the portion of the premium that covered its enrollees. But recent changes require plans to ensure that contracting physicians carry the

insurance. A HCFA spokesperson said the agency "has decided to remain silent on who's going to pay, allowing the plans and physicians to work the issue out on their own. We're assuming that in negotiations, managed care organizations and physicians will reach some kind of agreement."

The AMA is pleased with the new rules, according to Richard Deem, AMA vice president of federal affairs and coalitions. "We checked with various physicians and representatives when the regulations first came out and found out that it's a mixed bag out there in terms of the business relationships between the plans and the providers. We did hear from some physicians who said that plans were marking up the insurance. The other aspect is that if plans had to pay for the insurance, they might lower the capitation that physicians were receiving to pay for it. We finally concluded that physicians would be able to purchase the product at a better price if they were able to shop around."

Either aggregate or per-patient

ISMIE offers Physician Provider Stop-Loss

ISMIE offers Physician Provider Stop-Loss insurance to protect physicians, groups, clinics and corporations when medical expenses for their patients enrolled in managed care plans exceed the amount covered by capitated payments. The product can be purchased independently from ISMIE medical malpractice insurance.

ISMIE's stop-loss premiums are based in part on the terms of the capitated contracts and the amount of risk that physicians are willing to assume, either on a per-patient or an aggregate basis. The product can be customized to fit individual circumstances and applies to all capitated contracts a physician signs. Unlike the capitation stop-loss components often provided through managed care contracts, the terms – and the costs – of ISMIE coverage are clearly stated, according to an ISMIE analyst.

Under an exclusive arrangement, Aon Alliance has written the capitation stop-loss policy and will handle all related claims and underwriting.

For more information about ISMIE's Physician Provider Stop-Loss, call (312) 782-2749 or (800) 782-4767.

stop-loss insurance would satisfy the regulation, according to the HCFA spokesperson. The HCFA rule specifies that aggregate stop-loss must cover 90 percent of the cost of referral services that exceed 25 percent of potential payments. Physicians and groups can then be liable for only 10 percent. Per-patient stop-loss must be based on the physician or physician group's patient panel size and must cover 90 percent of the referral costs that exceed the per-patient limits set by HCFA. The physician or group may purchase the type of insurance that is best suited to cover

the referral risk.

HCFA also requires managed care plans to provide satisfaction surveys for current Medicare and Medicaid enrollees, as well as those who have left the plan in the previous 12 months. If requested by Medicare or Medicaid beneficiaries, managed care plans must now disclose whether any of their contractors or subcontractors use physician incentives that affect referral services. In addition, HCFA now requires plans to disclose such incentives as capitation, withholds or bonuses. ■

MALPRACTICE ROUNDUP

Patient wins \$8 million in informed consent case

Because a 27-year-old divorced mother wasn't informed of alternatives to an above-the-knee amputation following a collision with a drunken driver, a New York jury awarded her \$8 million for pain, suffering, lost wages and home care.

In Taromina vs. Columbia Presbyterian Hospital, a plastic surgeon and plastic surgeon resident performed a local muscle flap procedure to treat severe leg fractures. The woman's attorneys claimed the physicians should have taken precautions by saving residual tissue for use as a below-the-knee stump in case the surgery failed, according to the December 1996 issue of Medical Litigation Alert.

The procedure did fail, requiring an above-the-knee amputation and permanently confining the patient to a wheelchair. The patient maintained the physicians should have known that seropurulent drainage under the calf muscle would doom the flap procedure to failure. Her expert witnesses said that the flap muscle became necrotic, causing the need for amputation, and that a free flap procedure using tissue from her arm had been warranted instead of the local flap procedure.

The patient said she would have agreed to a microsurgical procedure if the surgeons had presented it. The physicians maintained there was only a 5 to 10 percent chance that a microsurgical procedure would have allowed her to avoid the higher amputation.

Eye specialist found negligent in delayed tumor diagnosis

A New York man who initially complained of double vision in his right eye won a \$6.1 million award from an ophthalmologist who failed to diagnose the brain tumor causing the problem.

In Baumgarten vs. Slavin, a Nassau County, N.Y., Superior Court found the ophthalmologist negligent for failure to diagnose, also awarding \$3.6 million to the patient's wife, according to the Feb. 17 issue of the National Law Journal.

The ophthalmologist found an abnormality in the patient's CT scan results, diagnosing it as an inflammation, not as a brain tumor, the plaintiff's attorney said. When a treatment of prednisone had little effect and an angiogram ruled out an aneurysm, the physician suggested that the patient see a psychiatrist.

Another ophthalmologist also failed to detect the tumor until a second CT scan led to the correct diagnosis. Radiation killed the tumor but caused the patient to lose all sight in his right eye and half of the sight in his left eye. In addition, the radiation destroyed much of the patient's pituitary gland and triggered seizures.

The plaintiff's attorney charged that the delayed diagnosis caused more tissue to be exposed to the radiation, which caused permanent damage. Two physicians involved with the case settled with the patient and his wife for \$1.5 million, and the jury trial proceeded solely against the ophthalmologist who administered most of the treatment.

Edgar OKs extra funds for AIDS drugs

ROUNDUP: Legislators consider drive-through mastectomies, genetic testing. BY JANE ZENTMYER

[SPRINGFIELD] In response to their constituents' health care concerns, state legislators have developed more than 200 bills that are pending in the Illinois General Assembly. ISMS is monitoring the following bills:

FUNDING FOR AIDS DRUGS

Gov. Jim Edgar signed a bill Feb. 20 that earmarks an extra \$5 million in state

revenues and authorizes an additional \$4 million in federal funds to help low-income Illinoisans get medications to fight AIDS. The funds will be distributed through the AIDS Drugs Assistance Program, which is administered at the state level by the Illinois Department of Public Health. The Senate approved the measure on Feb. 6, and the House passed it on Feb. 19.

The demand for protease inhibitors created a funding shortfall for ADAP, according to Tom Schafer, IDPH spokesperson. The state spent \$2.4 million on the program during the 1994-95 fiscal year. IDPH added a protease inhibitor to its formulary in January 1996, and six months later the program's costs jumped to \$5.8 million. To maintain its current formulary for this fiscal year, ADAP is projected to need \$9 million.

In 1996, the state tried to close the funding gap and cover the costs of the protease inhibitor by eliminating some drugs from the formulary. Some of those drugs will be reinstated and two more

protease inhibitors will be added to the formulary as a result of the supplemental appropriation, which will be used throughout the rest of this fiscal year and early into the next fiscal year, Schafer said. IDPH is also considering a possible \$12,000 annual cap on individual benefits to control ADAP spending, he added.

The ISMS Board of Trustees agreed Feb. 1 to support legislative efforts to fund ADAP appropriately.

DRIVE-THROUGH MASTECTOMIES

Under consideration are bills that end so-called drive-through mastectomies. Sen. Kathleen Parker (R-Northfield) sponsors S.B. 711, which requires insurers to cover a minimum 96-hour hospital stay for mastectomy patients.

The measure doesn't require a longer stay if attending physicians determine that a shorter stay would not pose a risk for their patients. Insurers must cover patients who see their physicians or receive home visits by nurses within the first 48 hours of an early discharge.

The bill applies to patients covered by individual or group policies for accident and health insurance or managed care plans; Medicaid recipients; employees of county, municipality and state government and other government bodies; and individuals insured by companies normally exempt under ERISA.

Another Senate bill, S.B. 17, is sponsored by Sen. Arthur Berman (D-Chicago) and also requires insurers to cover a minimum 96-hour hospital stay.

In the House, sponsors of H.B. 107 include Rep. Rosemary Mulligan (R-Des Plaines), Speaker Michael Madigan (D-Chicago), House Republican Leader Lee Daniels (R-Elmhurst), Rep. Daniel Burke (D-Chicago) and Rep. Judy Biggert (R-Westmont). The House overwhelmingly approved a similar bill in fall 1996, but that measure stalled in the Senate.

ISMS supports requiring insurers to cover minimum 96-hour hospital stays for mastectomy patients.

TORT REFORM REVERSAL

H.B. 61, sponsored by Rep. Thomas Dart (D-Chicago), reverses some provisions of the 1995 tort reform legislation. The current law requires plaintiffs to submit affidavits of merit detailing the reasons the suits are being filed. Each affidavit must include certification from the reviewing physician attesting to the action's merit. Before tort reform, physicians who verified an action's merit didn't have to identify themselves.

The House bill requires the reviewing health professional's identity to be deleted from material related to the lawsuit. ISMS opposes the measure, which will be considered by the House's Civil Judiciary Committee.

PHYSICIAN-ASSISTED SUICIDE

Rep. Doug Scott (D-Rockford) introduced H.B. 691 in February to legalize physician-assisted suicide in Illinois. Physicians would be allowed to prescribe drugs to end the lives of their patients who have six months or less to live, according to the bill.

The bill addresses patients' mental competence at the time decisions are made. Patients must ask a licensed physician for suicide assistance twice during a minimum two-week period; a primary care physician must document treatment options besides suicide; the physician

(Continued on page 15)

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Physicians and lawyers find common ground

Graduates of MD-JD programs bring a unique perspective to medical issues.

BY TODD SAVAGE

When a 16-year-old girl sought treatment at the emergency department at St. Francis Medical Center at the University of Illinois at Peoria, emergency workers weren't sure about how to interpret a statute about "emancipated minors." Ordinarily, they would have needed parental consent to treat the young patient, but the girl had already given birth. The question was whether the birth had emancipated the patient, allowing her immediate treatment.

The question was answered by a recent graduate of the MD-JD program at Southern Illinois University at Carbondale. "I actually went out to the trunk of my car and got the relevant statute," said James Hubler, MD, a first-year resident in emergency medicine at St. Francis. "I knew the answer, but [I wanted] to reinforce it to the nursing staff. Several of the attending physicians thought someone who had delivered a child could make a decision for only that child, and that is not true." With Dr. Hubler's legal help, the doctors and nurses proceeded to treat the girl without parental consent.

Dr. Hubler isn't an aberration. More students are intrigued by the interface between medicine and law, maybe partly because medicine and law intersect more these days through such issues as medical malpractice, patient privacy and confidentiality, domestic violence, genetic testing and informed consent. Whatever the reason, nine universities, including two in Illinois, now offer MD-JD programs, according to the Association of American Medical Colleges in Washington, D.C.

Last year, SIU graduated its first class of students with this interdisciplinary education. SIU's MD-JD program admitted its first class of students in 1989. After medical students began expressing interest in legal and policy issues related to their work, program co-director Theodore LeBlang initiated discussions between the deans of the school's medical and law schools.

THE SIU PROGRAM is structured to give students the opportunity to earn the two degrees concurrently over six years. They spend the first two years in law school in Carbondale where they take courses focusing on health law. In the third year, the students shift their attention to medical training and spend the remainder of the time in Springfield at the school's clinical campus. During their senior year, students enroll in 14 weeks of electives devoted to medicine, law and health policy on such topics as forensics, the legal aspects of hospital-physician relationships, bioethical issues and public health law. This cluster of classes integrates everything they've studied.

LeBlang said he expects most of the MD-JD program graduates to practice medicine, drawing on their legal backgrounds not only to set policy, but also to help with their clinical work.

An MD-JD program has been offered by the University of Illinois at Urbana-Champaign since 1978. The program takes about seven years to complete and is part of the university's Interdisciplinary Medical Scholars Program, which allows students to earn concurrent medical and graduate or professional degrees.

Tony Waldrop, program director, said, "We are very

much committed to [students'] being involved in activities beyond just practicing medicine. We're hoping that they will be involved in developing policy and dealing with the changes that are occurring in medicine."

After completing his degree at the U of I in 1985, Paul Hattis, MD, put his training to work. Now a senior medical consultant to Brigham and Women's Hospital in Boston, Dr. Hattis recently received grant funding to study the obstacles physicians face in carrying out public health efforts in a managed care environment. He previously served as a hospital's vice president for medical affairs and helped develop national policy by writing testimony for congressional committees and briefs to the U.S. Supreme Court. "The degree has given me both a language and a set of skills to take on that sort of breadth of role," he said.

He's not alone. Some current students who have chosen the MD-JD route said they think their degrees will help them make more of a difference. "I would like to use my dual degrees to impact people's lives, to affect more people through involvement with health care reform, particularly in the public health arena," said Senait Fisseha, a second-year SIU medical student who serves as an alternate delegate for the ISMS Medical Student Section. Fisseha said she would like to use her background to develop legislation or regulations that would benefit health care delivery.

Although physicians and attorneys may meet on opposite sides of the courtroom in malpractice cases, programs offered by SIU and the U of I demonstrate the common ground of both professions. "When you consider we both fight for patients' rights and we both could be patients' advocates, we don't have to be enemies," Fisseha said. "A physician and a lawyer could work together to educate patients about their rights. Together, these two fields can bring a greater good for patients, physicians and everyone." ■

On your behalf

Physicians don't necessarily need medical-legal degrees to understand health care law. The ISMS Medical Legal Council deals with many legal issues that affect medicine and has even prepared a set of summaries and opinions about state and federal laws pertinent to medical practice.

The guidelines deal with such issues as care for AIDS patients, the closure of a medical practice, do-not-resuscitate orders, liens, living wills and sub-

poenas. They've been distributed to all Illinois county medical societies, ISMS staff and attorneys participating in the ISMS



Lawyer Referral Network to help when members have questions on legal topics.

In January, the council considered guidelines for medical record retention, issues related to ancillary service providers in workers' compensation cases and home health care services in Medicare settings.

This information, published as space permits, is reprinted from the Illinois Department of Professional Regulation's monthly disciplinary report. IDPR is solely responsible for its content.

October 1996

Ho Kyung Lee, Chicago – physician and surgeon license indefinitely suspended due to an outstanding tax liability owed the Illinois Department of Revenue for tax years 1984, 1985, 1989, 1991 and 1993, and failing to file Illinois individual tax returns for the years 1991, 1992 and 1993.

Abelardo Sanchez, St. Louis, Mo. – physician and surgeon license suspended for two years followed by probation for three years after being convicted of one count of felony mail fraud and being sentenced to 15 months' incarceration.

Janice Young, Dunlap – physician and surgeon license indefinitely suspended due to an outstanding tax liability owed the Illinois Department of Revenue for tax years 1984, 1987, 1988, 1989, 1990, 1991 and 1992, and failing to file Illinois individual tax returns for the years 1993 and 1994.

November 1996

Richard Brady, Morris – physician and surgeon license temporarily suspended pending proceedings before the Medical Disciplinary Board after criminal indictments were issued against him for aggravated criminal sexual assault, computer fraud, aggravated insurance fraud, vendor fraud and theft.

Richard Adley Caldwell, Chicago – temporary physician and surgeon license issued on probation until permanent license is issued due to history of alcohol dependency.

Braham Dewan, West Frankfort – physician and surgeon license placed on probation for one year for allegedly prescribing controlled substances to patients who may have exhibited drug-seeking behavior.

Robert Easton, East Peoria – physician and surgeon license reprimanded for writing prescriptions for a fellow employee of the Department of Corrections, contrary to that department's policy, and failing to maintain a patient record for this employee.

Young Ho Kwon, Ramsey, N.Y. – physician and surgeon license indefinitely suspended after being disciplined in the state of New York.

Robert J. Lee, Evergreen Park – physician and surgeon license temporarily suspended pending proceedings before the Medical Disciplinary Board after examining physicians and staff concluded he suffers from opioid and benzodiazepine dependency and is cognitively impaired.

Albert L. Reynolds, Hazelcrest – physician and surgeon license placed on probation for two years for acting in a dishonorable, unethical or unprofessional manner in prescribing Tylenol 3 and Meprobamate for nontherapeutic purposes.

James H. Seubold, Aurora – physician and surgeon license fined \$2,000 for failing to comply with the terms and conditions of a previously ordered probation.

Vincent Steward, Chicago – physician and surgeon license revoked for violating the terms and conditions of a previously ordered discipline by knowingly taking delivery of a controlled substance and aiding and abetting his wife, an unlicensed person, to prescribe, order, purchase, receive and sell controlled substances.

Woodrow Terrell, Sequin, Texas – physician and surgeon license reprimanded after he allegedly pre-signed prescriptions that were misappropriated by an employee.

December 1996

Leonard Arnold, Chicago – controlled substance license restored to probation for two years.

Zarina Bandukwala, Park Ridge – physician and surgeon license reprimanded for failing to comply with the terms of a previously ordered probation.

Anthony P. Dalton, Viroqua, Wis. – physician and surgeon license indefinitely suspended for failing to comply with the terms and conditions of a previously ordered probation.

Marion Douglas Dorn, Eldorado – controlled substance license revoked after allegedly diverting prescriptions for Hydrocodone to himself during a relapse of chemical dependency.

Angelo V. Gagliano, San Antonio, Texas – physician and surgeon license reprimanded and fined \$250 after being disciplined in the state of Texas.

Vinod Goyal, Barrington – physician and surgeon license placed on probation for two years and fined \$4,000 for allegedly quoting a charge for a procedure that was substantially lower than the ultimate cost for the procedure to four patients.

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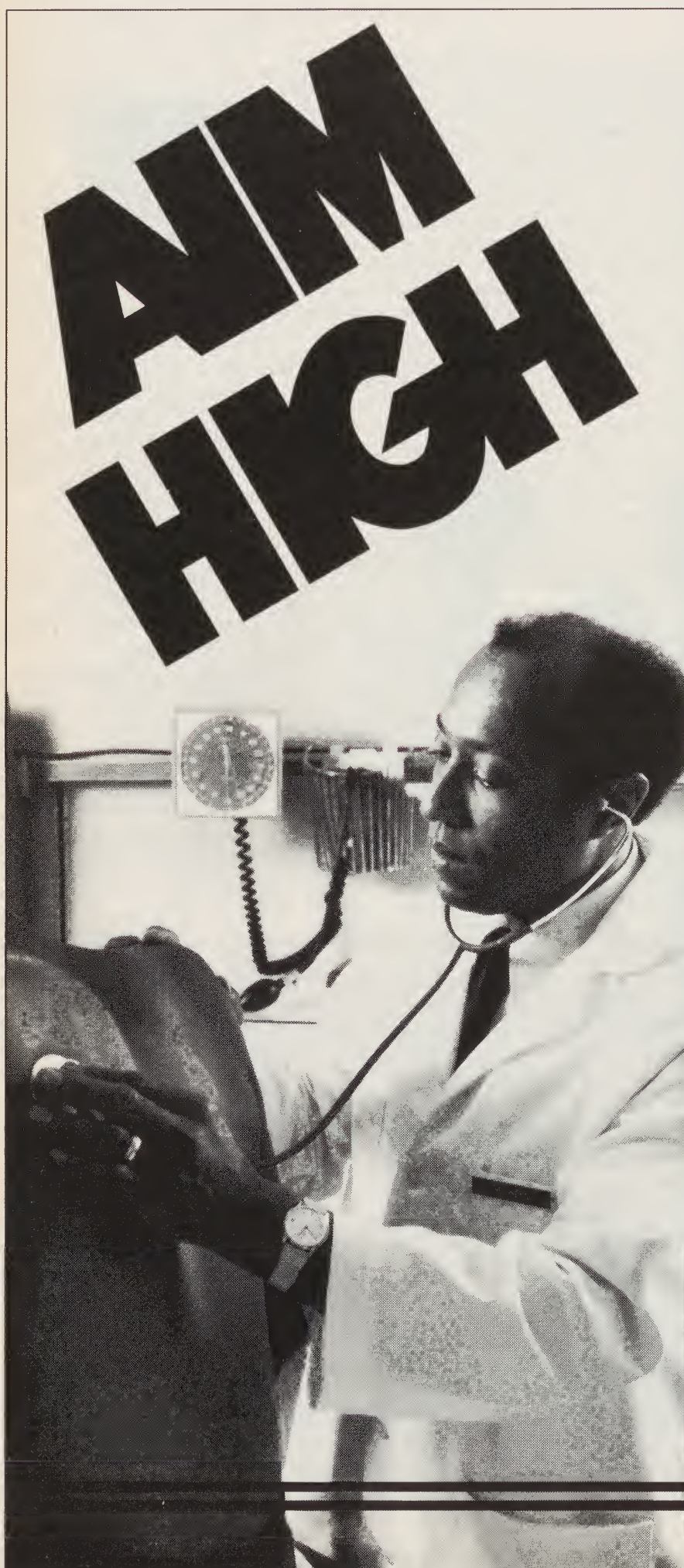
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Medicare focuses

(Continued from page 1)

initial and periodic assessments to carry out a comprehensive care plan that meets the resident's medical, nursing, mental and psychological needs, the carrier said. The care plan must be developed and revised by at least the attending physician and a registered nurse who has responsibility for the resident. Physicians should document the care plan on their order sheets, which must be signed by the physician and the nurse.

Dr. Busby said lab work and routine patient screenings are the two biggest areas of Medicare abuse. "We're talking about individuals who visit nursing homes on a routine basis to perform tests that add nothing to the diagnosis and treatment of the patient — for example, an optometrist who performs a standard battery of tests on patients every month, even though there is no indication that they need it. Or standing orders for lab tests, when there is no documented reason for them. It all adds up to big dollars."

Documentation is critical, according to John Schneider, MD, chairman of ISMS' Third Party Payment Processes Committee. "Although a variety of specialty services, such as audiology, optometry and podiatry, are covered Medicare services, they are only covered if there is medical justification for them. If a physician feels that it is necessary for a patient to have tests done on a repetitive basis — for example, a renal profile every three or four months because of the medications or the condition of the patient — those need to be indicated on the record. It's not sufficient for physicians to order interventions by other providers and laboratory tests unless they've carefully documented on the record the indication for that request or order."

The nursing home initiative is consistent with HCFA's goal to tackle Medicare fraud in 1997. The impetus for HCFA's latest attack on fraud is nearly a dozen provisions contained in the Health Insurance Portability and Accountability Act of 1996. HCFA intends to focus on preventing abuses instead of trying to recover payments made for improper services, according to a statement given to a U.S. House subcommittee last year by Judith Berek, HCFA's senior adviser to the administrator on intergovernmental coordination.

Berek's statement noted that one of the most effective ways to prevent fraud and abuse is to inform providers about which services are covered, how to code documents properly and how to improve billing practices.

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House panel

(Continued from page 1)

ation. Consumer advocates discussed patients' needs for information about all aspects of their health care plans, increased access to specialists and a fair process to appeal plan decisions.

Not all the groups testifying supported managed care reforms. Gerald Suchomski, MD, president of the Illinois Academy of Family Physicians, told legislators that his group thinks that proliferating regulations may increase costs without improving outcomes. "We also have concerns regarding the protection of patients for provision of quality of primary care. We believe that providers trained in primary care do that with the highest quality and the best cost efficiency."

He was referring to a concept included in MCPRA that would grant patients with a chronic illness – for example, insulin-dependent diabetes, severe asthma or cancer – the right to choose a "principal care physician" who specializes in that area. The principal care physician would need to be a plan member and have a referral arrangement with the primary care physician. Patients would be able to see their principal care physician without referrals or prior ap-

provals from the primary care physician.

Rep. Rosemary Mulligan (R-Des Plaines) asked Dr. Suchomski whether family physicians have a vested interest in the current gatekeeper arrangement in most managed care plans because of their training as gatekeepers. "What managed care has recognized is family practice provides a model that works best," Dr. Suchomski responded.



"The opposition of family physicians to oversight of managed care seems to ignore the existence of these [chronically] sick patients," said internist Craig Backs, MD, president of the Illinois Society of Internal Medicine. For optimal management, chronically ill patients often require expertise that's beyond the training and experience of most primary care physicians, including himself, Dr. Backs said. But many managed care plans offer financial incentives to physicians

to discourage referrals to specialists, he added. That, combined with a system that encourages some physicians "to know everything," can create problems for patients.

Physicians and managed care entities might object to the principal care provider mandate because of concerns about losing control of the financial risk accepted, but plans can develop payment

MCPRA garners bipartisan support

The following are MCPRA's sponsors in the General Assembly:

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mechanisms to deal with those concerns, Dr. Backs continued. "Internists feel that the benefit of chronically sick patients' having access to the most appropriate medical care should override the financial concerns that the principal care provider concept creates for some physicians and managed care organizations."

Legislators also heard from representatives of managed care groups about their self-regulation. Patients have the right to complain about plan practices to state agencies, said Barry Averill, vice president of Humana Health Care Plans Inc. and a board member of the Illinois Association of Health Maintenance Organizations. "There are safeguards now. That's not saying we can't improve."

Dr. Olson noted that many legislators have cited complaints from their constituents about managed care practices. Public and legislative support led to the

1996 passage of laws requiring insurers to pay for a minimum 48-hour hospital stay for mothers and their newborn infants and granting women direct access to their obstetricians or gynecologists. This year legislators are also considering bills mandating insurance coverage of minimum 96-hour hospital stays for mastectomy patients.

"Doctors are concerned that what is shaping up as a condition-by-condition approach to managed care oversight, as well-meaning as it is, could take too long and leave too many of our patients out," Dr. Olson told the committee. "Instead, we want you to consider one overall, comprehensive approach to assure the rights of every Illinois patient, regardless of the condition they may face or the source of their health insurance. A comprehensive approach to patient rights will assure no one is left out."

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Humana acquires Health Direct from Advocate Health Care

[OAK BROOK] Humana Inc. added almost 52,000 policyholders to its membership in January with its buyout of Health Direct Inc. from Oak Brook-based Advocate Health Care, according to Humana. Advocate sold the Des Plaines-based HMO for \$20.5 million.

Based in Louisville, Ky., Humana is one of the largest publicly traded managed care organizations with 4.8 million medical members in primarily 22 states and the District of Columbia.

"This transaction will enhance Humana's ability to market its managed health care services in the Chicago market – particularly our Gold Plus plan for Medicare beneficiaries," said Barry Averill, vice president of Humana's managed care plans in Chicago. Humana serves about 45,000 Medicare members in the Chicago area. With the buyout of Health Direct, Humana will add about 4,000 more Medicare patients.

As part of the transaction, Humana will provide health coverage for five years

for Advocate's estimated 23,400 employees and their dependents, and health care services to Health Direct's 28,300 members in Chicago. Advocate will also provide care to all Chicago-area Humana members for the same five-year period. To support the increased patient load, Humana will pay \$2.5 million for Advocate to develop a network infrastructure.

Advocate Health Care was formed in 1995 through the merger of Lutheran General HealthSystem and Evangelical Health Systems.

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Coalition, physicians

(Continued from page 1)

according to coalition members. The federal law, which becomes effective in January 1998, excludes businesses with 50 employees or less. H.B. 111 would apply to most of the plans not covered under the federal legislation, such as plans serving smaller companies.

The state bill requires that mental health coverage mirror the amounts, deductibles and co-insurance requirements that exist for other illnesses. It covers only serious mental illnesses caused by biological-physiological brain disorders or psychosocial factors limiting patients' ability to function. Included are depression, panic disorders and bipolar disorders. The measure doesn't apply to "life problems" such as divorce or job loss.

Often the financial burden for treating these people falls on the Illinois taxpayers.

"Often the financial burden for treating these people falls on the Illinois taxpayers," said Rep. Lauren Beth Gash (D-Deerfield), the bill's lead sponsor. "What's interesting is that the cost of insuring these citizens is relatively low. Seven studies in recent years have concluded that if serious mental illnesses were covered to the same degree as other medical problems, premiums would rise very little."

Other House sponsors include Reps. Patricia Lindner (R-Sugar Grove), Judy Erwin (D-Chicago), Sara Feigenholtz (D-Chicago), Carolyn Krause (R-Mount Prospect) and Carol Ronen (D-Chicago).

States with mental health parity laws haven't experienced large increases in insurance premiums, Gash added. In

Maryland, for example, psychiatric stays declined despite a 1993 insurance reform law requiring parity psychiatric coverage, according to the coalition. In 1993, about 24 percent of patients stayed longer than 20 days in private psychiatric hospitals. The year after the law was enacted, the number dropped to 18 percent.

"It's important to remember that as we analyze how much something will cost, we also have to analyze the cost of not doing that thing," Gash said.

"In fact, if we made medical treatment available on the basis of economic efficiency, severe mental illness would be at the top of the chart," said Sen.

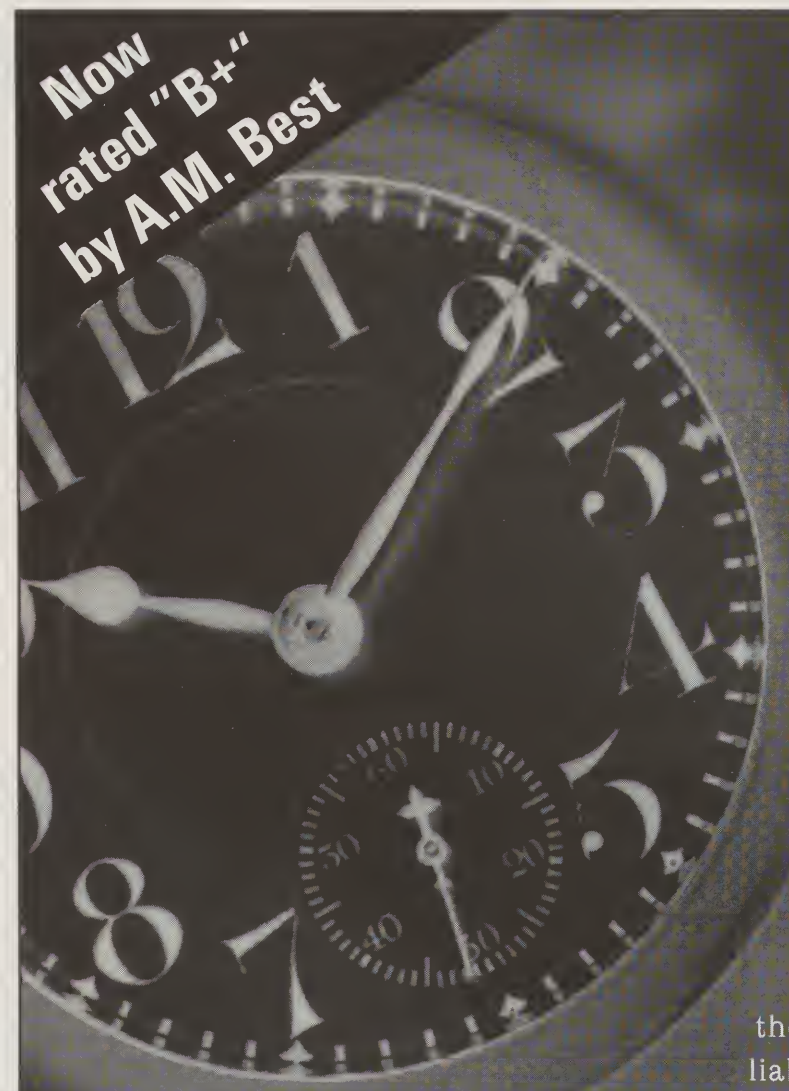
Thomas Walsh (R-Westchester), who will be the bill's lead sponsor in the Senate. "If we choose to ignore this problem, further down the road we will pay more."

The nationwide treatment success rate for clinical depression is 85 percent; panic disorder, 80 percent; bipolar disorder, 80 percent; and schizophrenia, 60 percent, according to the coalition. Common heart treatments like angioplasty and artherectomy have success rates of 41 percent and 52 percent, respectively, according to coalition data.

A recent statewide poll on mental health parity showed that 69 percent of

the respondents believed insurance companies discriminate against people with mental illnesses and 87 percent would favor a law requiring insurance companies to provide equal coverage for mental illness.

"Based on these results, it looks as if some of the public prejudice against the mentally ill is fading," said Arden Barnett, MD, chairman of the Illinois Psychiatric Society's Governmental Affairs Committee. "That's very good news for those who suffer from these diseases. It also indicates a very strong support for ending health insurance discrimination against the mentally ill in this state." ■



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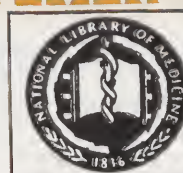
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PAGE 7

Illinois Medicine

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PAGE 6

Reimbursements for physicians will remain steady

MEDICAID: Budget reflects taming of 'monster' payment backlog. BY JANE ZENTMYER

[SPRINGFIELD] Gov. Jim Edgar's proposed fiscal 1998 budget reflects the state's continuing efforts to maintain the level of physician reimbursement while paying bills promptly. "The billion-dollar backlog that resulted from the excesses of the '80s is gone," Edgar said when he unveiled the budget before a joint session of the General Assembly on March 5. "The Medicaid monster has been tamed. We are paying our bills on time."

The \$34.5 billion proposed budget reflects a slight decrease from last year. Although no new funds were allocated to increase reimbursement for health care services, physicians can expect to have state checks for their services within a reasonable time. "The budget has sufficient monies to assure that physicians will be reimbursed in a timely fashion, i.e., approximately 20 days after the submission of a clean bill," said John Schneider, MD, chairman of ISMS' Third Party Payment Processes Committee.

During the past few years, the state has decreased the payment cycle for physician reimbursement, according to Dean Schott, spokesperson for the Illinois Department of Public Aid. In fiscal 1994, for example, the payment cycle was more than 100 days, and the state had more than \$1.36 billion in bills on hand at the end of the fiscal year, Schott said. By June 30, the end of fiscal 1997, the state expects to have \$254 million in medical bills, with a payment cycle of about 22 days, according to budget figures.

IDPA's total appropriation for medical services in fiscal 1998 is expected to increase slightly.

(Continued on page 10)

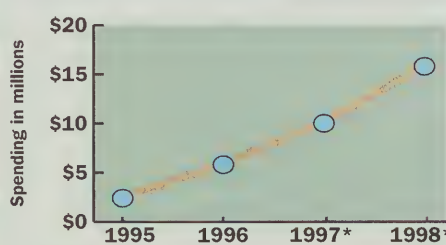
Edgar's budget expands state AIDS drug assistance

FORMULARY: Plan would prevent program from facing bankruptcy. BY JANE ZENTMYER

[SPRINGFIELD] Although new protease inhibitor drugs are available to help HIV and AIDS patients, the cost of providing them to Illinoisans threatened to bankrupt the state's AIDS Drugs Assistance Program early this year. In outlining his fiscal 1998 budget to the General Assembly on March 5, Gov. Jim Edgar offered to increase funding to help the program remain solvent and to add more prescription drugs to the formulary for HIV and AIDS patients.

"This budget proposal funds one of the most comprehensive HIV or AIDS drug assistance programs in the country," Edgar said. "New drug combinations have shown remarkable success in treating persons with HIV and AIDS. Through this program, we will provide these life-enhancing drugs to

State spending on AIDS Drug Assistance Program



*Projected funds
Source: Illinois Department of Public Health

those with the most financial need, allowing them to continue leading independent, productive lives."

The governor's \$34.5 billion budget proposal includes a \$190 million fiscal 1998 budget for IDPH, with about \$15.8 million earmarked for ADAP. Earlier this year, ISMS' Council on Medical Service agreed to support an increase in ADAP funding, with the Board of Trustees adopting the council's recommendation on Feb. 1.

ADAP helps lower-income AIDS and HIV patients who are not poor enough to qualify for Medicaid or who have no insurance or insufficient insurance to afford the drugs themselves. The additional ADAP funding is based on about \$8.7 million in federal funds and \$7.1 million in state funds, said Tom Schafer, IDPH spokesperson.

In fiscal 1995, Illinois spent \$2.4 million on the program, and about the same

(Continued on page 11)

INSIDE

ISMS
Speakers Bureau
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PAGE 2

Physicians can
decide whether
to notify HIV
patients' spouses
about risk

PAGE 3

Never
underestimate the
value of a good
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PAGE 4

DEPARTMENTS

Malpractice
Roundup.....6

Classifieds8

Senate OKs lower blood alcohol level

BILLS: Legislators also act on smoking bans, intact dilatation and extraction.

BY JANE ZENTMYER

[SPRINGFIELD] As the lead Senate sponsor of S.B. 8, a bill that would lower the state's legal level for blood alcohol content from .10 to .08, Sen. Christine Radogno (R-La-Grange) decided to learn first-hand whether the lower level really affected driving skills. She signed up for a test sponsored by the Illinois State Police that would measure her ability to drive with a level of .08.

When Radogno began the test, held at the state police's training facility, she had not had anything to drink. She maneuvered around the cones on the track without knocking over one. Eight drinks and more than two hours later, Radogno tried the test course again with a level of .08. This time she hit the cones and even dragged one under her car without realizing that it was stuck. Clearly, she said, the alcohol impaired her driving skills.

As lawmakers considered S.B. 8, Radogno shared her experience: "[The test] was very helpful to me because I wanted to be sure when I testified both before the committee and the full Senate that I was truly con-



Ron Ackerman

ISMS PRESIDENT-ELECT Jane Jackman, MD, is flanked by Illinois Rep. Tom Ryder (R-Jerseyville) (left), and Thomas Houston, MD, as they testify about three anti-smoking bills at a House Executive Committee hearing on March 5.

vinced that we were not talking about social drinking."

The bill, sponsored by Rep. Thomas Johnson (R-West Chicago), passed the full Senate by a vote of 48-8 on March 6 and now goes to the House for consideration. In 1996 the ISMS House of Delegates adopted a position that supports lowering the level to .08.

Legislators also deliberated on other health-related bills including the following:

ANTI-TOBACCO MEASURES

Legislators on the House Executive Committee tackled anti-smoking proposals at a subject matter hearing March 5. Among individuals testifying

(Continued on page 10)

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ISMS Speakers Bureau gets MDs talking

Volunteers discuss health issues with seniors, teens.

BY JANE ZENTMYER

When Raynelda Hidalgo, MD, stood in front of a class of at Hamline Elementary School in Chicago on Feb. 11, she did more than discuss the prevention of AIDS and other sexually transmitted diseases. She served as a role model.

"I grew up in Chicago, and it's really important for kids to see that there are people from Chicago who become successful, because a lot of kids in the inner city don't think they can succeed," said Dr. Hidalgo, an Ob/Gyn who practices in Chicago. "I hope I made a little bit of difference."

Dr. Hidalgo is one of more than 260 physicians who volunteer their time with the ISMS Speakers Bureau. The bureau provides guest speakers at the request of schools, civic and social groups and other educational forums. ISMS also encourages physicians to set up their own speaking engagements.

"We like to think that we educate our patients when they're in the office and we've got a chance to talk to them," said Charles Drueck III, MD, chairman of the ISMS Council on Public Relations and Membership Services. "But to talk to a large group when they're not anxious or

threatened by their own illness is sometimes as lasting and carries as much long-term improvement in terms of the health of the community."

The council develops programs to enhance relationships between the media, the public and physicians. It coordinates ISMS' teen and senior programs using volunteers from the Society's

Speakers Bureau to distribute information on health issues. The teen program, for example, now focuses on the prevention of AIDS and other sexually transmitted diseases. Physician volunteers like Dr. Hidalgo do

short presentations and answer questions from their audiences.

The Society also provides speakers and schools with an award-winning video about AIDS prevention, as well as brochures printed in English and Spanish. Last year, physicians gave more than 50 presentations through the teen program and distributed nearly 100,000 brochures.

To help senior citizens, physicians discuss practical information older adults need for their medical care. In the past year, ISMS distributed more than 245,000 of its "A Personal Decision"

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BROOKFIELD ZOO, including a walrus prop, was the setting for a seminar on women and cardiovascular health held by the West Suburban Region of the American Heart Association on Feb. 19. Panelists Mary Ann Malloy, MD (left), and Joan Briller, MD, emphasized that heart disease is the No. 1 killer of American women.



Matt Ferguson

kits, which include information about living wills and durable power of attorney for health care. The Society also distributed more than 2,000 copies of the "Partners for Health" kits to help seniors handle their health care by organizing their medical bills and listing their medications.

To help physician volunteers hone their public speaking skills, last fall ISMS sponsored nine free seminars, attended by more than 200 physicians. Professionals gave tips on delivering effective speeches, with breakout sessions focused on AIDS, seniors' issues and the Managed Care Patient Rights Act. Participants earned credit for continuing medical education.

Although Dr. Hidalgo didn't attend a public speaking seminar, she said that ISMS background materials prepared her for many of the questions the students asked. "I enjoyed it once I got over my stage fright," she said, adding that she would speak again to young people.

By participating in the Speakers Bureau, physicians become more visible in their communities and develop leadership roles on public health issues, Dr. Drueck said. Dr. Hidalgo agreed: "We should give something back to our community and take the time out of our day to try to talk to kids in some way."

To volunteer for the Speakers Bureau, call ISMS at (312) 782-1654 or (800) 782-ISMS.

Report points to need for improved early childhood health care services

ADVOCACY: Prenatal care, early intervention can prevent developmental problems. BY CHRIS PETRAKOS

[CHICAGO] Poverty, neglect and the lack of prenatal care are the three biggest threats to the well-being of Illinois children, according to a study released in January by Voices for Illinois Children, a not-for-profit advocacy group. The report, titled Illinois Kids Count, revealed some bleak statistics about the health of Illinois children:

- ☐ More than 10,000 children, or one of every seven, are born into families headed by single, teen-age mothers who haven't finished high school.
- ☐ The rate of child abuse and neglect rose 28 percent in the state between 1993 and 1995.
- ☐ One of every four children is born without first trimester prenatal care.

"The most critical finding in our report this year is the notion of starting early," said Jerome Stermer, president of Voices for Illinois Children. He cited several programs around the state — for example, Healthy Families America in Aurora — that support children who are at risk of failure.

The report also addresses the need for health insurance for children. About one in seven children in the state is uninsured. The number of uninsured children jumped from about 420,000 in 1991 to 474,000 in 1993, an increase of 54,000.

On the federal level, the issue of children's health insurance is gaining some momentum. President Clinton's proposed 1998 budget would spend \$18.4 billion through 2002 to cover half of the nation's 10 million uninsured children. States would receive some of that money to help subsidize coverage for poor working families that don't qualify for

Medicaid and for parents who have lost a job and whose families are temporarily without insurance. In addition, the budget requests expanding Medicaid to cover nearly 1 million children who are between ages 13 and 18 and in low-income families.

Samuel Flint, associate executive director of the American Academy of Pediatrics, noted that the proportion of children covered by private health insurance is slightly higher in Illinois than in the rest of the United States, due in large part to the state's combination of Rust Belt industries and union traditions. Overall, though, the trend is toward less employer-sponsored health insurance.

Health care has historically focused on cures rather than prevention, which has affected youngsters, Flint said. One way of countering the problem is through the passage of the Child Health Insurance Reform Act by the General Assembly. The bill requires health insurance companies regulated by the state to provide children under age 6 with full coverage for preventive services.

In addition, the Illinois Chapter of the American Academy of Pediatrics developed a bill that would create the "Healthy Start" program, which would provide low-income uninsured youngsters with such outpatient services as immunizations, preventive care and developmental assessments.

ISMS House of Delegates' position supports coverage for supervision services for children under the age of 19 through individual and group policies of accident and health insurance, HMOs, limited health service organizations or point-of-service contracts.

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IDPH targets spousal notification of HIV

DISCLOSURE: Law allows physicians to decide whether to notify based on circumstances of case.

BY JANE ZENTMYER

[SPRINGFIELD] Last month the Illinois Department of Public Health sent letters to those Illinois physicians who are most likely to work with HIV-positive patients to help doctors decide whether to tell their patients' spouses about exposure to HIV. The initiative is in compliance with the Ryan White Comprehensive AIDS Resources Emergency Act, which urges states to make a "good faith effort" to notify spouses about their possible exposure to HIV — or risk losing federal AIDS funding.

Most HIV-positive patients notify their partners after talking with their physicians, said Chet Kelly, chief of IDPH's AIDS Activity Section. However, the Illinois AIDS Confidentiality Act permits physicians to directly notify the spouses of their HIV-positive patients "provided that the physician has first sought unsuccessfully to persuade the patient to notify the spouse or that [following] a reasonable time after the patient has agreed to make the notification, the physician has reason to believe that the patient has not provided the notification." The law has been in effect since 1990.

"The treating physician is in the best position to make the determination as to whether the spouse should be notified," said IDPH Director John Lumpkin, MD. "This law protects the physician when carrying out those decisions made in the best interest of the patient and his or her spouse." The state law defines a spouse as any individual who is a marriage partner or was one during the 10 years before an HIV diagnosis, Kelly said.

ISMS legal counsel stressed that this law does not create a legal duty or obligation for physicians to notify the spouses of HIV-positive patients. Instead, the law allows physicians to decide whether they should notify spouses based on the facts and circumstances of each case. In addition, this provision applies only to couples who are legally married. Illinois law provides good faith immunity from civil and crim-

inal liability for any disclosure or nondisclosure of a test result to a spouse, according to counsel.

Through the Ryan White CARE Act, the federal government provides Illinois with funding for state AIDS programs, including the AIDS Drug Assistance

Program. During the 1998 fiscal year, Illinois will receive \$10.5 million, Kelly said. To receive that money, states must meet certain requirements such as making the good faith effort to encourage spousal notification. "It creates a legal requirement for the state," Kelly added.

"It does not create a legal requirement for physicians in those states."

If they choose, physicians may refer their HIV-positive patients to partner-notification services available through local health departments or they may provide identifying information to IDPH for

follow-up without giving the name of HIV-positive patients, Kelly said. The state's mailing to physicians includes a list of all HIV counseling, testing, referral and partner-notification programs run by local health departments. The law prohibits officials from informing individuals who have been exposed to HIV about who identified them, according to Kelly. ISMS supports IDPH's notification of sexual partners of HIV-positive individuals.

"We cannot by law tell a contact that this is the person who named you, whether it's HIV or syphilis," Kelly said. "There are situations, particularly if contacts have had only one partner, that they'll easily deduce who would have named them. But, again, we cannot tell them that. I think the point is that a patient's confidentiality is protected as fully as humanly possible."

The state has offered partner-notification programs at counseling and testing sites for several years, according to Kelly. Before the new federal requirement, the programs included discussions about sexual contacts but did not specifically mention husbands or wives. Procedures at those sites have now been revised so that counselors talk to HIV-positive patients about the possibility of informing current or former spouses, Kelly said.

Physicians who didn't receive the IDPH mailing may request it by calling the department at (217) 524-5983. ■

This law does not create a legal duty or obligation for physicians to notify the spouses of HIV-positive patients.

State: Don't forget to report Lyme disease

PUBLIC HEALTH: Cause of drop in number of cases may be fewer transmissions or fewer reports. BY JANE ZENTMYER

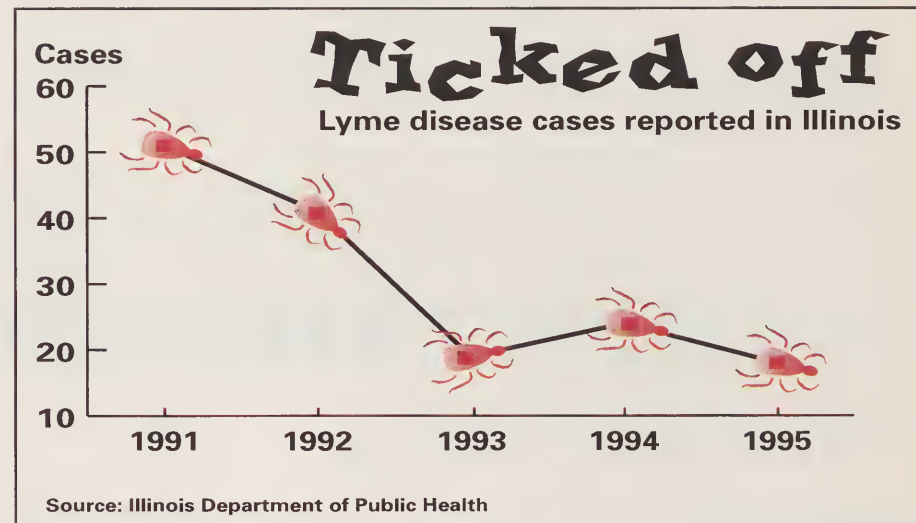
[SPRINGFIELD] Despite a drop in the number of Lyme disease incidents reported in Illinois between 1991 and 1995, the Illinois Department of Public Health is urging physicians to continue watching for symptoms of the illness. "We want to remind physicians that the disease is there," said Carl Langkop, chief of communicable disease control at IDPH. He added that doctors should report suspected cases to health officials.

The number of reported Lyme disease cases dipped from 51 in 1991 to only 18 in 1995, but the reason for the decrease is unclear, Langkop said. It could reflect declining transmissions or simply fewer reports to health officials, he added. Between 35 and 56 percent of the cases reported during those four years resulted from out-of-state infections, according to IDPH.

Two counties, Ogle and Rock Island, have ticks infected with the Lyme spirochete, according to Langkop. Six other counties — Carroll, Grundy, Lee, Monroe, Will and Winnebago — are home to small

populations of deer ticks that have not demonstrated Lyme disease infection.

Lyme disease can be difficult to diagnose, Langkop said. In 60 to 80 percent of cases, patients will show an erythema migrans within three to 32 days after a tick bite. Other symptoms include fatigue, malaise lethargy, myalgia, headache and a stiff neck. Left untreated, patients may experience cardiac or neurological disorders, joint pain or arthritis. ■



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EDITORIAL

How we say it

The expression that "it's not so much what we say as how we say it" may apply to physician-patient communication, according to a study published in the Feb. 19 issue of JAMA. The study focused on the differences in conversational styles between primary care physicians who had never been sued vs. those with histories of malpractice claims. The upshot was a strong link between lawsuits against physicians and lapses in how doctors presented information to patients. Beyond helping to avoid litigation, good communication increases patient satisfaction, improves compliance rates and can even result in better outcomes, said a study author from the University of Chicago Medical Center.

In the study, physicians who were strong communicators were shown to spend slightly more time with patients — 18.3 minutes vs. 15 minutes. They also explained what they were doing by saying, for instance, "Now I'm going to examine you, and then we'll talk about your problem and I'll answer any questions." In addition, physicians asked patients for their opinions about medical problems and treatments and encouraged patients to be expansive by using prompts such as "tell me more about that."

Authors of the study said that active listening not only elicits important clinical information, but also reassures patients that physicians care about them.

Other studies support the importance of listening and communicating well. A

study conducted by the Wayne State University Medical School found that physicians interrupted patients within 18 seconds of greeting them. Patients listed up to five matters they wanted to discuss with their doctor, but often they reported being unable to cover even one.

A study conducted by doctors at the California College of Medicine and Massachusetts General Hospital showed that doctors spent just one minute giving information to patients during a 20-minute visit even though the doctors thought they had spent almost 10 minutes doing so.

ISMIE tracks the reasons that plaintiffs file lawsuits against physicians. Of the nine top reasons, several relate to communication: The subsequent treating physician criticized prior care; there was a personality conflict between the physician and the patient or office staff and the patient; or the patient thought that access to the physician was restricted or that vital information was withheld.

To help physicians improve their communication skills, ISMIE devotes nearly an hour of its three-hour Loss Prevention Seminar to that subject. The seminar will be offered May 1 in Springfield and May 17 in Oak Brook. For more information, call ISMIE's Risk Management Division at (312) 782-2749 or (800) 782-4767, ext. 1327.

Physicians are caring and compassionate healers. We just need to make sure our patients know that.

PRESIDENT'S LETTER

Physician profiling

Sandra F. Olson, MD



Raw malpractice data does not reflect the quality of care.

You have been hearing quite a bit about physician profiling lately, both in the lay press and from the medical community. This is a very serious and potentially volatile topic for all who consider it: doctors, legislators and the public.

The AMA has launched the American Medical Accreditation Program, whose purpose is to credential individual physicians based on performance and establish a registry of information that can be furnished to organizations for credentialing purposes. This data bank would include information about physicians' medical education, postgraduate training, practice experience, etc. The program's comprehensive approach aims to replace duplicative profiling activities that physicians are subject to, especially by managed care plans, and set a quality standard for credentialing.

Another approach to obtaining physician-specific data has emerged. In Massachusetts, a law has recently gone into effect whereby the state's Board of Registration and Medicine releases physicians' records to the public upon request. People who call the board can learn about malpractice claims against doctors, along with the disposition of the cases, and all disciplinary actions, and awards, honors and articles published in medical journals. The only information that is not released is what religion the doctors practice and whether they perform abortions. Data is also furnished that compares each physician with his or her colleagues in the same specialty. I've heard reports from colleagues in Massachusetts who say this program is very controversial and provides potentially misleading information, which can prove to be a great disservice to patients.

The disturbing reality is that there is movement to start a similar program here in Illinois, and H.B. 73, the Patient Right to Know Act, has been introduced in the General Assembly. Self-styled consumer watchdog groups have been attacking Illinois for not setting up a central registry of malpractice data and for not disciplining

doctors sufficiently. Interestingly, this watchdog group claimed 83 sanctions were given in Illinois during 1996, but in actual fact, there were 148 disciplinary actions involving physicians — an 80 percent difference. These groups relate that data to the erroneous assumption that there is a mandatory annual "bounty," or quota of disciplinary actions, that should be enforced against physicians.

The public already has access to IDPR disciplinary actions, as they are a matter of public record. Soon they will be on the Internet. The department collects information on felony convictions, hospital or professional society disciplinary actions, and malpractice judgments and settlements in Illinois. If the department believes that there is a quality of care issue based on this data, they can then act accordingly. So, in effect, the information reported to the public in Massachusetts is already reported to our professional disciplinary board, which then considers it and acts. We think that is the appropriate way to handle such issues, namely, by peer review.

An article in the Feb. 19 issue of JAMA demonstrates the fact that raw malpractice data does not reflect the quality of care. That article showed that communication with patients, or lack thereof, was the major basis for malpractice suits. We already know that outstanding doctors who practice in high-risk and technically advanced specialties are more subject to malpractice suits. We've gotten so good that the public expects that every outcome will be perfect and that all medical problems can be solved and have a happy ending. Doctors strive for perfection, but unfortunately, mishaps still occur — that doesn't mean they're cases of malpractice.

Let's take the high road. The issue here is very clear. We must be responsible for our own professional actions or we will lose our right to be called a profession. This is serious business if we want to maintain control of the practice of medicine, but a raw data profiling system in Illinois is not the route to take.

GUEST EDITORIAL

The power of employer coalitions

By Howard R. Veit

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Health plans, take heed! Employer coalitions are revolutionizing the way health care is purchased in the United States. As profit margins have narrowed, companies have become bolder and more innovative in seeking to reduce employee health care costs while maintaining or improving quality of care.

To lower costs, some employers have chosen to limit benefits, restrict the number of plans offered, decrease coverage to dependents or increase out-of-pocket costs for patients. These employers found reducing benefits easier than exploring alternative health care arrangements.

Today's savvy health care purchasers are forming employer coalitions to buy health care coverage, contract directly with providers and share quality data to facilitate purchasing decisions. Employers are realizing that the relentless pursuit of lower costs does not lead to a value-based health care system. Instead, coalitions are demanding a new kind of accountability from providers and payers.

Local health care markets are changing to accommodate the needs of these more demanding purchasers. In some cases, the employer coalition has so much leverage that it can completely reshape the health care market. Nowhere is this more evident than with the Business Health Care Action Group in Minneapolis-St. Paul.

BHCAG, a coalition of 24 self-insured employers, represents 400,000 members – an enormous segment of the Twin City population. Among the employers are American Express, General Mills, Honeywell and 3M.

BHCAG's original strategy was to purchase an established HMO network on a self-funded basis rather than to contract directly with providers. BHCAG selected HealthPartners to provide third-party administrator services and access to its comprehensive network of

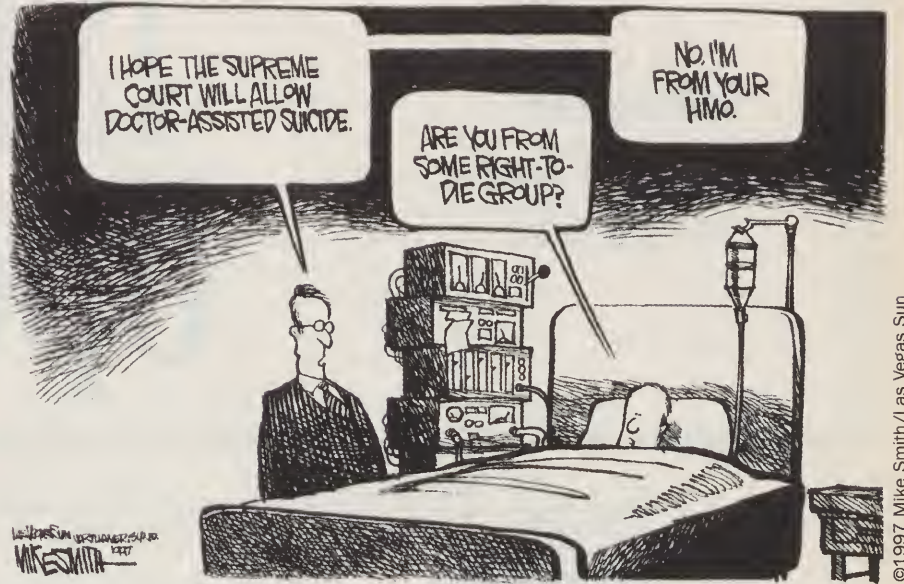
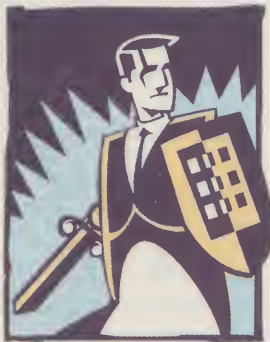
providers and facilities.

In 1994, employees were invited to join BHCAG's managed care/point-of-service plan, Choice Plus. Offered as one of several plans, it attracted nearly 100,000 members. Employers were free to develop their own Choice Plus rating strategies to provide financial incentives to plan members.

With two years of experience and more than 10 percent savings in their pockets, BHCAG members stepped back to evaluate the future Twin Cities health care environment. From its inception, BHCAG emphasized both quality and cost-effectiveness in its program. With three local managed care plans (representing 80 percent of the metro area managed care enrollment) and three dominant hospital/integrated delivery systems, the coalition became concerned that competition in the marketplace had been reduced below its optimal level. Concluding that it had, the coalition revised its mission to improve quality, provider competition, consumer decision-making and the efficiency of health care delivery.

BHCAG developed a new strategy of direct contracting to increase competition among providers. It encouraged providers to form "care systems" – integrated delivery systems that offer enrollees a full array of health care services.

Care systems submit bids for a claim target (a phantom capitation figure per member per month) based on the experience of the entire BHCAG population. They also submit fee schedules to reimburse providers through the self-funded



employers' bank accounts. Quarterly adjustments to the fee schedules ensure that actual experience closely tracks the quoted claim target. Quoted claim targets are risk-adjusted, according to the Ambulatory Care Groupings of the population actually enrolled in the care systems.

Employees choose care systems after reviewing published quality indicators, including patient satisfaction and cost. Employers set contributions based on the cost of the lowest-priced care system. Employees pay the difference between the care system they choose and the lowest-cost plan. Care systems, rather than broad provider networks, compete directly for enrollees. Thus, consumer choice drives reform.

An employer coalition strategy has transformed the competitive playing field in Minneapolis-St. Paul by bypassing the three large HMOs as middlemen and allowing 15 care systems to compete on their own merits. A consumer-driven market is now a reality. The leverage gained through the collective power of an employer coalition has reformed the health care market.

Veit is managing principal of Towers Perrin's health practice.

IMPAC annual meeting scheduled for April 19

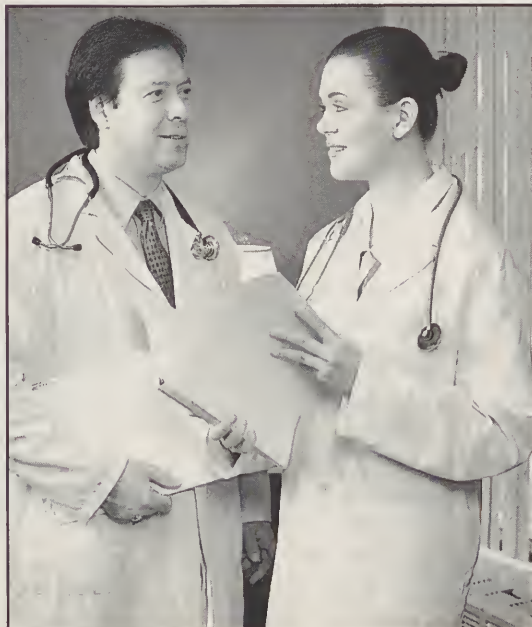
The Illinois State Medical Society Political Action Committee will hold its annual meeting at the Oak Brook Hills Hotel on Saturday, April 19, immediately after ISMS' annual Public Affairs Breakfast.

Business will include the election of IMPAC Council members. Nominees for appointment or reappointment to the council are Edward Fesco, MD, LaSalle; Jere Freidheim, MD, Chicago; Raymond Hoffmann, MD, Rockford; Harold Jensen, MD, Chicago; Sandra Olson, MD, Chicago; Edward Ragsdale, MD, Alton; John Schneider, MD, Chicago; M. LeRoy Sprang, MD, Chicago; Alan Roman, MD, Chicago; and Pam Taylor, Danville.



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ISMIE Update

New ISMIE product helps protect physicians from employer liability

Policy minimizes the risks when employees and others sue. BY JANE ZENTMYER

Consider this scenario: After a male co-worker repeatedly makes negative comments about women, a female receptionist sues the medical clinic where she works for sexual harassment. The result is a settlement for the receptionist and payment of her legal fees. Although legal action might have been avoided by preventing the co-worker from continuing with his disparaging remarks, the clinic could have

been protected by ISMIE's new professional liability product, the Physician Employment Practices Liability coverage.

"Physicians are now responsible for things that physicians would never have thought of years before," said Harold Jensen, MD, chairman of the ISMIE Board of Governors. "The goal of ISMIE's Seamless Coverage is to protect physicians and their practices as well as we can. Our new Employ-

ment Practices Liability coverage is one more piece of a bridge to support physicians in troubled times."

All employers should consider the possibility that the way they hire, fire or just treat their employees could lead to some kind of difficulty, according to an ISMIE representative. "People tend to sue because they think they have a grievance, and as an employer, you have to protect yourself against those

kinds of actions." Employee lawsuits may allege such mistreatment as disability discrimination, sexual harassment or age discrimination.

Another possible situation might involve a job applicant who claims discrimination when she isn't hired for a clerical position. The failure to hire her, the applicant charges, violates the Americans with Disabilities Act. The practice, however, maintains the applicant doesn't have the background needed for the position.

All employers, including physicians, face more and more of these lawsuits, the representative said. For solo practice physicians, employment practice liability ranks second only to medical malpractice among liability risks these days. The bigger the practice, the greater the risk of being sued for employment practices, according to ISMIE.

"This really becomes one of the most necessary types of insurance because there are a lot of claims, and some of them — many of which you read about in the paper — are very severe claims," said Ed Robin, president of the Encino, Calif.-based NAS Insurance Services Inc., the firm managing the ISMIE policies on behalf of Lloyd's of London. Robin added that the three main liability exposures are wrongful termination, sexual harassment and discrimination of all kinds.

The three main liability exposures are

- ✓ wrongful termination
- ✓ sexual harassment
- ✓ discrimination

"It's good coverage for a bad exposure."

Although all employers are at higher risk of being sued by an employee, physicians have special needs, Dr. Jensen said, and ISMIE's new coverage addresses them. For an additional premium charge, physicians can get a special endorsement for lawsuits that may be filed by nonemployees with whom they work while caring for patients, the ISMIE representative explained. For example, if a nurse working for a hospital claimed a physician harassed her while caring for a patient, related litigation would be covered.

"With this new product, we can continue to offer one-stop shopping to our physicians for all their insurance needs," Dr. Jensen said. "As a physician-owned company, we have responded to the needs of our physician policyholders by crafting new policies like the Employment Practices Liability to fit the needs of the solo physician and a group or clinic."

For more information, call ISMIE at (800) 782-4767. ■

MALPRACTICE ROUNDUP

Physician, hospital owe no duty to anguished 'bystanders'

The Texas Supreme Court ruled that the hospital and the attending physician who delivered a stillborn infant were not responsible for the "bystander mental anguish" alleged by the parents who witnessed the birth, according to the February edition of Medical Malpractice Law & Strategy.

In an earlier trial in *Edinburgh Hospital Authority vs. Trevino*, jurors ruled that the hospital's negligence caused the parents of the baby to experience mental anguish and awarded \$750,000 to each parent. The physician settled with the parents prior to trial.

The state Supreme Court, however, disagreed, stating that the mother could not recover for anguish as a bystander to the fetus' injury because the hospital did not owe a duty to the fetus unless it was born alive.

The husband claimed he suffered mental anguish after watching the hospital's negligent treatment of his wife, but the court found the hospital had no legal duty to the husband to provide competent medical care to his wife or to the fetus.

The court also rejected the theory that the husband had experienced mental anguish as a bystander when he observed his wife's heavy bleeding, including blood clots, which he said he believed to be the fetus.

In its ruling, the court said that the provider's primary duty is to the patient, not to relatives who may be unable to distinguish between "helpful and harmful medical care."

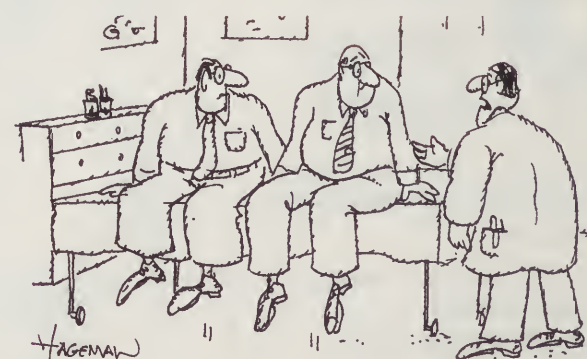
Patient, home health agency share liability in overdose

Even though a physician and a nurse knew a patient had a history of psychiatric disorders and drug abuse, a California Superior Court jury ruled the medical team was not liable in the woman's death from an overdose of pain medication through a PCA pump.

In *Garcia vs. Innofusion Inc.*, a California jury found a home health care agency 50 percent liable for allowing the patient access to the pain medication controls, according to the January issue of Medical Malpractice Law & Strategy. The patient was also found to have been 50 percent liable.

Following back surgery, the patient was sent home with an epidural catheter attached to the pump and a 960cc bag of a morphine and mardocaine combination for pain, according to an attorney for the patient's family. The defendant nurse, who worked for the home health care agency, left the key for controlling the medication pump. The patient used the key to increase the level of medication for her back pain.

The plaintiff attorney argued that because of the patient's history, the agency should not have allowed a key — or such a large amount of the medication — to be kept in her home. The defense responded that the patient should have known not to use the key.



"We'll start by taking your blood pressure. Would you and your lawyer please roll up your sleeves?"

Physicians speak out at managed care reform hearings

Emergency physician, dermatologist and oncologist talk about their patients and the need for change.

BY JANE ZENTMYER

When a 44-year-old man experienced chest pains at home, he called 911 and was transported to the local hospital's emergency department. The emergency physician took the patient's history, performed a physical exam, blood tests and an electrocardiogram, and determined the patient had indigestion. The hospital discharged the patient to follow up with his own physician.

The one thing the patient had not done during that incident was to call his managed care plan for authorization, said Daniel Sullivan, MD, president of the Illinois College of Emergency Physicians. "That plan does not reimburse emergency department visits for non-emergencies. [Because] indigestion is not an emergency, the plan did not pay for the ambulance transport or for the service."

A month later, the patient again felt severe chest pain and shortness of breath. He remembered his last experience and called the managed care plan first. The plan representative told him to stay at home and rest, Dr. Sullivan said. An hour later the patient was transported to the emergency department and died.

Dr. Sullivan shared this story when he testified before the House Committee on Health Care Availability and Access at a hearing in Springfield on Feb. 26. The committee is holding a series of hearings so that lawmakers can hear testimony on managed care reform. The General Assembly is currently considering more than 200 bills related to managed care. One of the many related issues is access to emergency care and authorizations.

"ICEP is greatly concerned about the impact of managed care on patient access to emergency services," Dr. Sullivan said. "[Emergency] services and access to emergency care should not be denied to the reasonable, prudent person who believes that those services are necessary."

PATIENTS SHOULD BE ENCOURAGED to seek immediate care for emergency situations from any provider without prior approval, according to the 1997 Managed Care Patient Rights Act, a comprehensive managed care reform bill developed by ISMS. MCPRA defines emergency care as a "medical condition of recent onset and severity that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that urgent or unscheduled medical care is required."

The act guarantees health care rights to patients in five basic areas: quality, choice, individual respect, advocacy and information. The bill was originally

introduced last year and was refined and reintroduced this session as H.B. 603 and S.B. 705. The measure's bipartisan support is exemplified by its 42 sponsors in the House and 10 sponsors in the Senate.

ICEP, which is reviewing MCPRA, developed H.B. 643, which would create the Access to Emergency Services Act. On March 4, the committee sent the bill to the full House for consideration.

Another issue addressed by MCPRA and ICEP's bill is the problem emergency physicians face after they've stabilized patients and need authorization from managed care plans. Often they can't reach the plans, Dr. Sullivan said.

"The managed care plan must have someone available 24 hours a day, seven days a week," Dr. Sullivan said. "We need contact within 30 minutes, so patients can be referred, admitted and transferred to a tertiary care facility or whatever their needs may be."

Both MCPRA and the emergency physicians' bills would require plans to respond to requests for authorization for any nonemergency care needed by stabilized patients within 30 minutes of notification. If physicians received no response, the services would be considered approved.

"There is no question that managed care was created in this country to fulfill a variety of needs," said Springfield dermatologist Stephen Stone, MD, past president of the Illinois Dermatological Society, who also testified at the hearing. "Unfortunately, for many managed care organizations, costs become the primary issue, with the goal of developing acceptable – but unfortunately neither convenient nor first-class – health care to its participants."

Dr. Stone said that costs can be reduced by allowing for easier access to specialists. In his written testimony, he cited a patient who was referred to him for treatment of a widespread fungus infection. The patient had been given a prescription for 100 tablets of itraconazole, which cost about \$1,000, but her condition could have been treated for \$5 or \$6 with two tablets of ketoconazole. "[Dermatologists] can come up with a much more rapid diagnosis of some skin problems," he said at the hearing.

James Wade, MD, a Decatur oncologist, told legislators about a national study on how managed care affects oncology. He said the study showed that 66 percent of the plans that oncologists worked with required approval before patients could get diagnostic tests, biopsies or access to oncologists.

Dr. Wade noted that under MCPRA, patients with chronic conditions like cancer could choose a principal care physician to manage their care. That would mean that patients would not have to get approval from their primary care physicians each time they needed to see their principal care physician or when they needed a test or treatment for their chronic condition.

"This act, once approved, will help protect patients and will help ensure fair and equitable practices in the insurance industry," Dr. Wade said. "It will assist all people to be better consumers of health care by giving them choices that will be more readily available. It will truly enhance value in health care delivery." ■



Dr. Stone



Dr. Sullivan



Dr. Wade

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Senate OKs

(Continued from page 1)

was ISMS President-elect Jane Jackman, MD, who explained the Society's position on three anti-smoking bills that mirror House of Delegates policies and positions. "These are small steps to try to decrease tobacco consumption," Dr. Jackman said after the hearing.

One bill, H.B. 359, prohibits tobacco companies from giving out free tobacco samples. First-time offenders would be fined \$100, and repeat offenders would be fined \$250. Dr. Jackman said the issue is that "it's just too easy for chil-

dren to get hold of tobacco, which makes it too easy to get started and addicted." The measure is sponsored by Reps. Tom Ryder (R-Jerseyville) and Douglas Scott (D-Rockford), and it has been assigned to a House subcommittee.

H.B. 567 would have amended the Illinois Clean Indoor Air Act and banned smoking in all restaurants. Restaurants now have nonsmoking and smoking sections, but "it's pretty hard to tell the difference because the smoke drifts over to the nonsmoking section," Dr. Jackman said. "What we are concerned about is the effect of second-hand smoking on people." The bill, sponsored by Rep. Car-

olyn Krause (R-Mount Prospect), stalled in the House Executive Committee.

A third measure, H.B. 570, would ban smoking in health care facilities including hospitals, ambulatory surgical treatment centers, postsurgical recovery centers, nursing homes, physicians' and dentists' offices and all other health care facilities. "Most doctors have had the scenario where a patient who just had a heart attack sneaks out for a cigarette while still in the hospital because the nicotine addiction is so bad," Dr. Jackman said. "Our thinking is that health care facilities [are] supposed to be promoting healthy behavior."

The bill, amended to exclude nursing homes, passed out of the House Executive Committee by a vote of 15-0.

PARTIAL-BIRTH ABORTION BAN

The Senate passed the Partial-Birth Abortion Ban Act March 18 by a vote of 44-7. The bill bans intact dilatation and extraction, or partial-birth abortion, except if the mother's life is endangered by a physical disorder, physical illness or physical injury, and no other medical procedure would save her. Exceptions include life-endangering conditions caused by or arising from the pregnancy itself.

Anyone performing a partial-birth abortion would face a Class 4 felony, which carries a one- to three-year jail term and fines. The father and maternal grandparents could also pursue civil damages. A woman on whom a partial-birth abortion was performed could not be prosecuted for violating the act. The bill is sponsored by Sen. Chris Lauzen (R-Geneva). An identical bill, H.B. 382, is sponsored by Rep. Peter Roskam (R-Wheaton). It moved from the Executive Committee to the House floor with a 10-0 vote on March 12.

At its November 1996 meeting, the ISMS Board of Trustees approved the introduction of a resolution at the AMA's interim meeting in December requesting that the national association "immediately and diligently work to oppose all intact dilatation and extraction procedures, and that this opposition be AMA policy." Intact dilatation and extraction, according to the submitted resolution, "is a particularly offensive procedure that is difficult to support as a medical procedure and is not performed for early termination of pregnancy." In addition, there is no medical necessity for an intact dilatation and extraction, according to the resolution.

At its interim meeting, the AMA House of Delegates decided to take no position and work to bring a more scientific grounding and appropriate practice guidelines to the debate, according to the Dec. 23/30 issue of AM News. ■



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Persons at high risk for whom an initial vaccine may be administered include all people age 65 and older; immunocompetent adults who are at increased risk of pneumococcal disease or its complications because of chronic illness (e.g., cardiovascular disease, pulmonary disease, diabetes mellitus, alcoholism, cirrhosis, or cerebrospinal fluid leaks); and individuals with compromised immune systems (e.g., splenic dysfunction or anatomic asplenia, Hodgkin's disease, lymphoma, multiple myeloma, chronic renal failure, HIV infection, nephrotic syndrome, sickle cell disease, or organ transplantation).

Persons at highest risk and those most likely to have rapid declines in antibody levels are those for whom revaccination may be appropriate. This group includes persons with functional or anatomic asplenia (e.g., sickle cell disease, splenectomy), HIV infection, leukemia, lymphoma, Hodgkin's disease, multiple myeloma, generalized malignancy, chronic renal failure, nephrotic syndrome, or other conditions associated with immunosuppression such as organ or bone marrow transplantation, and those receiving immunosuppressive chemotherapy. Routine revaccination of people age 65 or older who are not at highest risk is not appropriate.

Reimbursements

(Continued from page 1)

tle more than \$2 million, or .06 percent, over the fiscal 1997 appropriation. However, the "physician line" – the budget line item reflecting funds earmarked for physician services – shows a 10.6 percent decrease because of the expected implementation of MediPlan Plus.

MediPlan Plus seeks to rein in the cost of the state's Medicaid program by moving more than 1 million recipients to managed care and is expected to be implemented this year. "It is presumed that the plan would result in more patients being enrolled in HMOs, which results in a shift of money from the physician line to an HMO line," Dr. Schneider explained. Physicians who treated Medicaid recipients through MediPlan Plus would be reimbursed from the money designated for managed care.

Before MediPlan Plus can be implemented, though, the Department of Health and Human Services requires the U.S. Health Care Financing Administration to approve all related documents. Those documents have been developed and forwarded, but delays at HCFA may delay program implementation. ■

Edgar's budget

(Continued from page 1)

amount was budgeted the next year. On Jan. 1, 1996, the state added a protease inhibitor drug, Invirase, along with another drug, Epivar, to its formulary. The combination of a protease inhibitor and other AIDS medications like Epivar and AZT form a "drug cocktail" that may mitigate the virus.

After the addition of Invirase, the state's ADAP expenses increased rapidly. By the time fiscal 1996 ended, the state had spent \$5.8 million on the program, Schafer said. "The whole country was caught by surprise that [the drug cocktail] would be as successful as it was."

As ADAP expenses rose, IDPH convened a medical issues committee, made up of physicians, patients with HIV or AIDS, a social worker, a medical ethicist and a pharmacist, to determine how to control the program's costs. In May 1996, IDPH reduced the number of drugs offered on the ADAP formulary from 110 to 28, Schafer said. But no new protease inhibitors were added.

"Even though we cut the number of drugs, the cost still went up significantly," Schafer said. When this fiscal year closes June 30, IDPH will have spent an estimated \$10 million on ADAP, he noted.

The whole country was caught by surprise that the drug cocktail would be as successful as it was.

The Illinois General Assembly and the governor approved a \$9 million supplemental appropriation for the ADAP program in February, a move designed to help fund the program through the end of fiscal 1997 and into the beginning of the next budget year. The supplemental funds are included in the program's budget estimates.

IDPH plans to increase the number of prescription drugs offered through the program to 61, including two new protease inhibitors drugs, Norvir and Crixivan. The state will also limit patients' monthly ADAP allowance to \$1,000, IDPH said. The drug cocktail costs an average of \$750 to \$1,050 per month, depending on a patient's prescription, Schafer said.

The changes become effective April 1. To be eligible, a patient must be diagnosed with AIDS or HIV, have a monthly income of no more than twice the federal poverty level and lack coverage for prescription drugs through insurance or other government subsidies, according to IDPH.

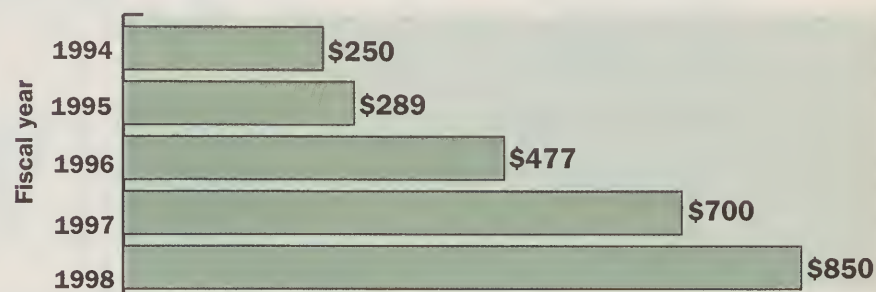
"The use of protease inhibitors in conjunction with other AIDS medicines has demonstrated an impressive ability to bolster the immune system of a person with AIDS or HIV," said IDPH Director John Lumpkin, MD. "By making all of

the latest drug therapies available, we are helping needy Illinoisans access medicines that offer hope for living with HIV."

Earlier this month, IDPH contacted ADAP drug recipients and physicians who prescribe through the program to inform them of the changes. Case managers at counseling and testing sites will give information to individuals who are newly diagnosed with HIV or AIDS, Schafer said.

For more information, call the AIDS hotline at (800) AID-AIDS or call the ADAP program directly at (217) 524-5983. ■

ADAP average monthly spending per patient



Source: Illinois Department of Public Health

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PAGE 7

Illinois Medicine

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Illinois joins
nationwide
debate on
partial-birth
abortion

PAGE 8

INSIDE

President's tour
links ISMS
with members



PAGE 2

House approves
ban on female
genital mutilation

PAGE 3

ISMS delegates
will debate
managed care,
public health
issues



PAGE 6

DEPARTMENTS

Malpractice
Roundup.....7

Classifieds11

Managed care reforms advance from committee to House floor

TESTIMONY: State Senate to conduct hearings. BY JANE ZENTMYER

[SPRINGFIELD] After several hearings about managed care reform and regulation, the Illinois House of Representatives' Health Care Availability and Access Committee voted in March to send ISMS' Managed Care Patient Rights Act and several other managed care reform bills to the full House for consideration.

MCPRA is a comprehensive bill that would protect five basic rights for all patients: quality, choice, individual respect, advocacy and information. It was introduced as H.B. 603 and S.B. 705 and has attracted bipartisan support in both chambers but faces an uphill battle.

Sen. Tom Walsh (R-Westchester), chairman of the Senate's managed care subcommittee, said, "The bills that have been proposed by, for instance, the Medical Society and the HMOs, are likely not going to pass out of our subcommittee. But what we are going to do is listen to the testimony of the HMOs and the Medical Society, the manufacturers, the dentists, businesspeople and anybody

else who has concerns with this." The Senate will begin hearings on managed care reform bills in April, but action may not come this session, Walsh said. "This could very well go on after session and into the veto session. We'll just have to see how things go once we begin hearing testimony and so

forth. If we're able to do it by the end of session, that will be great. But I think with the scope of this issue that it's going to take us much longer."

Walsh explained that senators will likely use one bill as a vehicle for managed care reform. "We are actually going to write the legislation, and that's going to be the managed

On your behalf

Unlike some narrowly focused managed care reform bills, MCPRA didn't pass last year because legislators needed more time to analyze the bill's comprehensive provisions.

In the intervening year, ISMS continued to refine MCPRA to better reflect Society positions and to incorporate suggestions from other physician and medical organizations. Among the ISMS groups working on MCPRA were the Council on Economics, the Governmental Affairs Council, the Third Party Pay-

ment Processes Committee and the Board of Trustees. Their efforts helped refine a bill that offers strong protections for patients.

Since its reintroduction this February, MCPRA has attracted bipartisan support in both chambers. More than 45 legislators have signed on as sponsors in the House while 10 lawmakers are sponsors in the Senate.

For more information about MCPRA, contact ISMS' Division of Governmental Affairs at (312) 782-1654 or (800) 782-ISMS.

care bill. So it won't be any of the bills that were sent to the subcommittee."

The House has similar plans for managed care legislation but began its series of hearings on the issue in early February. At a March 12 hearing, attorney Carol O'Brien, the AMA's division counsel for patient advocacy (Continued on page 14)

Alliance mini-internships give legislators, businesspeople a taste of medicine

ALLIANCE: Spending the day with a doctor dispels some misconceptions.

BY CHRIS PETRAKOS

[PEORIA] Mark Ayers, business manager of the International Brotherhood of Electrical Workers Local 34, said his one-day mini-internship was more than he expected. Meeting Ben Dolin, MD, at 7:15 a.m. at Methodist Medical Center in Peoria, he followed the gastroenterologist into the endoscopy lab where he witnessed biopsies and colonoscopies for the better part of the morning. Between procedures, the two occasionally left the lab to do assessments on recently admit-

ted patients. Through the afternoon, Ayers watched as Dr. Dolin saw a continuous stream of patients in his office.

"The biggest thing that struck me," said Ayers, "was that I had this false impression that doctors had a pretty cushy life. But after the experience, I have a totally different view, a great respect and appreciation for physicians. Dr. Dolin was on a dead run all day. We didn't have any lunch, and I was absolutely amazed, because I thought that I was in pretty

good shape, but by 4 o'clock, my feet were so tired. I realized that we had not sat down for one second."

"That was a slow day," Dr. Dolin said. This was the doctor's fourth experience in the Illinois State Medical Society Alliance mini-internship program. "I think it's necessary to let people know what we do. Legislators and businesspeople write about us, talk about us, legislate about us, but they frequently don't know what our (Continued on page 15)

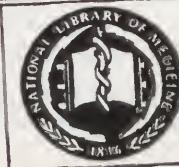
John McNulty



MATCH DAY JITTERS

had nothing on Northwestern University Medical School seniors (from left) Jean Goh and Shari Solomon and their friend Jeff Burns on March 19. Both women will start pediatrics residencies after graduation, with Goh at New York Hospital and Solomon at the Medical College of Wisconsin in Milwaukee.

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ISMS president's tour links the Society with members

Visits extend a personal touch. BY JANE ZENTMYER

Even though the annual president's tour can be challenging because of the intense statewide travel, ISMS President Sandra Olson, MD, said she has enjoyed traveling and meeting members more than any other aspect of her presidency.

"The president's tour is really the

highlight of the year," Dr. Olson said. "It's what you do. It's the raison d'être of the president – to go around and meet the members and inform them about what is going on statewide and even nationally in some instances and to be available to answer their questions."

Although the ISMS House of Dele-

gates Annual Meeting gives members a chance to express opinions on resolutions submitted and to change policies, the president's tour gives ISMS members the chance to talk to the president in a less-formal setting.

Throughout their terms, ISMS presidents visit as many county medical societies as possible, often meeting with the local media to discuss ISMS' positions on issues. The agendas may vary, but the president usually speaks about issues

ISMS is working on and answers questions.

"Whether we agree with their message or disagree with the point they're trying to put across, the presidents open [the meeting] up for questions for us to discuss with them," said Paul Nord, MD, president of the McLean County Medical Society.

"They seem to freely discuss issues and show us that they are indeed doing something for us that can affect our everyday medical practice."

When a president doesn't know the exact answer to a member's question, ISMS staff members help find it and pass along the information through a phone call or a letter, said Raymond Hoffmann, MD, immediate past president of ISMS. "We try to follow up on every single question or comment that we didn't have an answer to immediately."

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REPORT for Illinois Physicians

HEALTH CARE ANTI-FRAUD PROVISIONS

With the passage of the Health Insurance Portability and Accountability Act of 1996, (Kennedy-Kassebaum legislation), Congress has mandated an extensive new set of health care anti-fraud provisions that go far beyond any previous legislation. Physicians must be informed of these issues, which reach beyond the portability reform provisions that have generated the bulk of the discussion and debate.

The legislation creates the federal crime of health care fraud, which makes it illegal for anyone to "knowingly and willfully" execute a scheme to defraud any health care benefit program, in connection with the delivery of or payment for health care benefits, or to obtain, by means of false representations, any of the property of a health care benefit program.

The focus of the legislation is on increasing the federal government's ability to investigate and prosecute health care fraud, even when detected by commercial insurers in the private sector. Investigative and punitive options available to the federal government for dealing with private sector fraud will be similar to those that the government will employ for Medicare. They will be more complete and have greater breadth than present Medicare policies and procedures. This anti-fraud program, through the aggregation of data from multiple sources, will coordinate, oversee, and direct State and Federal enforcement efforts, with respect to health care fraud.

The Fraud Control Center (FCC) at Blue Cross Blue Shield of Illinois (BCBSI), in coordination with Kenneth L. Richmond, M.D., Medical Director, is charged with internal and external fraud detection, investigation, and prevention for the company and all of its subsidiaries. The FCC utilizes the skills and talents of Certified Fraud Investigators, who have come to BCBSI from diverse backgrounds. The major focus of the FCC investigations involves prepayment and post-payment claims audits as well as field investigations. All claims and customer service personnel are trained by the FCC in fraud awareness and often refer suspect claims and situations to Dr. Richmond for evaluation. Questionable charges, subscriber fraud, altered bills, foreign claims, specific provider investigations, and internal fraud and embezzlement all fall within the purview of the FCC. Additionally, the FCC works in cooperation with federal law enforcement agencies and the State's Attorney's office, to provide required documentation for cases under investigation and to prosecute health insurance fraud offenders when indicated. BCBSI is a corporate member of the National Health Care Anti-Fraud Association, and FCC members belong to the International Association of Special Investigation Units, the Association of Certified Fraud Examiners, and the Institute of Internal Auditors.

Although this may sound onerous, most readers will never encounter this process, as the honest mistakes we all make from time to time are not going to trigger a federal investigation. Nonetheless, we must recognize our responsibility and commitment to the communities we serve. Health care fraud, whether in the public or private sectors, hurts those least prepared to protect themselves. The costs of crime manifests itself in higher insurance premiums, higher individual and employer taxes, and service cutbacks due to the resulting constraints on resources.

*They show us
that they are
indeed doing
something for us.*

The tour is especially important to those physicians who may not have much contact with the Society, Dr. Nord said. "It lets the local physicians know that the people who are running the Society in the upper offices are doctors just like we are. They have to deal with many of the everyday problems and everyday opportunities that we have. It lets us see them on a personal basis."

The visit itself often sends a message that the Society is working to keep in touch with members across the state. "Fulton County is not a highly populated county, and we're a fair distance from Chicago and the bigger cities," said Ralph Harold, MD, an ophthalmologist and president of the Fulton County Medical Society. He added that when the president visits, "it makes us feel like we are not left out – that we are an important enough consideration to be included. That's very reassuring to those of us who practice medicine in a fairly rural county."

"They pay dues, and they want to have their say, and they want to hear what's happening for them [at] the Medical Society," Dr. Hoffmann said. "It's really a time when they can get to know their president."

Dr. Olson said the statewide tour has helped her understand how medicine is practiced throughout the state. One of the best perks is the chance to "meet with members, exchange ideas, get new ideas and get feedback on our programs and policies."

ISMS President-elect Jane Jackman, MD, will begin her term following the ISMS House of Delegates meeting in mid-April, and she's ready to start her tour. "To me, it's an opportunity to get out into the counties, which is where things are really happening, rather than up at the headquarters in Chicago. I hope to bring what I hear and see back to the Board of Trustees."

Illinois House passes bill banning female genital mutilation

CULTURE SHOCK: Illinois physicians see patients who have undergone the procedure. BY JANICE ROSENBERG

[SPRINGFIELD] In February, the Illinois House of Representatives approved a bill making female genital mutilation a Class X felony, and supporters of the legislation hope the bill will pass the Senate before the end of the current session. Sponsors of H.B. 106 are Reps. Rosemary Mulligan (R-Des Plaines), Suzanne Deuchler (R-Aurora), Mary Flowers (D-Chicago) and Jan Schakowsky (D-Evanston).

The two procedures involved in female genital mutilation are clitoridectomy, whereby the clitoris is excised, and infibulation, whereby the labia minora are clasped or stitched to prevent sexual intercourse. According to published reports, the surgeries are often performed without anesthetic in unsanitary conditions. After the surgery, women may bleed heavily and have severe pain, and may experience such problems as chronic pelvic and urinary tract infections, pain during sexual intercourse, complications in labor or childbirth, shock or death.

There is no medical indication for this procedure; it strictly resides around religious and cultural practices.

"Physicians don't want to be asked to do this, and we don't want laypeople doing it," Mulligan said.

The U.S. Congress passed a ban on female genital mutilation that became effective on April 1. The Illinois bill amends the state criminal code regarding genital mutilation, exempting surgical procedures performed in connection with labor, childbirth or male circumcision.

Today, female genital mutilation is practiced in 26 African countries, according to the New England Journal of Medicine, with an estimated 100 million women having undergone the procedure.

"In the Western community there's a general feeling that this is barbaric, but it has cultural and religious significance for

the people who practice it," said Chicago Ob/Gyn Pedro Poma, MD, chairman of the Illinois Section of the American College of Obstetricians and Gynecologists. "Unfortunately, it can lead to infections and the incapacity to perform sexually. There are many deaths in those

countries where it is practiced, especially during labor, if proper care isn't available."

"There is no medical indication for this procedure; it strictly resides around religious and cultural practices," said Pon Jola Coney, MD, chairman of the Ob/Gyn department at Southern Illinois University Medical School.

ISMS supports Mulligan's bill. At its 1996 annual meeting, the AMA House of Delegates adopted a policy condemning female genital mutilation, calling it a form of child abuse. The AMA recommended that physicians who are asked to perform the procedure counsel

the patient and her family about related health problems. The AMA said that if possible, physicians should refer such patients to social support groups to help them cope with changing societal customs.

Illinois physicians who care for patients who have had the procedure should try not to reveal that they are shocked, said Chicago Ob/Gyn Angela Barber, MD. She has performed pelvic exams on several women whose labia majora have been altered and delivered the babies of two such patients. During labor, Dr. Barber performed double episiotomies on her patients. ■

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EDITORIAL

Prevention pays

Not all kids in Illinois have the kind of access to preventive health care that we'd like them to have. The advocacy group Voices for Illinois Children reports that of the nearly 3.1 million children in the state, more than 13 percent are uninsured, and of the 61 percent of kids who have private health insurance coverage, one in eight lacks coverage for preventive care. About 26 percent of Illinois children are enrolled in Medicaid.

There is some good news, though. Gov. Jim Edgar announced in February that Illinois is among the top 10 states in the country in the percentage of 2-year-olds immunized against vaccine-preventable diseases – a dramatic improvement from the state's previous ranking in the bottom five states. The ranking came from a survey conducted by the U.S. Centers for Disease Control and Prevention.

More good news is that Illinois children who are uninsured, enrolled in Medicaid or lack preventive care coverage are eligible for free vaccines under the Illinois Vaccines for Children Plus program, which was endorsed by ISMS' Board of Trustees.

By enrolling in the program, physicians can make sure their patients are fully immunized according to the schedule of the Advisory Committee on Immunization Practices. Doctors pay no out-of-pocket expenses and can administer up to \$270-worth of free vaccine for each eligible child. Immunizations

included are hepatitis B, DTP, H. influenza B, polio, MMR and varicella.

To enroll, physicians fill out two forms and send them to the Immunization Program of the Illinois Department of Public Health, which oversees VFC Plus. Doctors who are imagining paperwork that rivals tax forms in complexity may be surprised at the simplicity of the VFC Plus forms. The provider profile asks for information and estimates about the patients who will be vaccinated so that the funding will come from the appropriate source and IDPH will know how much vaccine is needed for a two- or three-month supply. The provider enrollment form outlines the requirements of the program and asks for the doctor's signature.

Record-keeping is simple as well. Doctors need to document the date the vaccine was administered, the manufacturer and lot number, and the name, address and title of the person who gave the vaccine.

The estimated benefit-cost ratio of vaccines – dollars saved by society for every dollar spent – is more than 21:1 for MMR, more than 30:1 for DTP and more than 6:1 for polio vaccine, according to the CDC.

For more information on enrolling in VFC Plus, which about 1,500 physicians have already done, call IDPH at (800) 526-4372. We can't overlook opportunities to get our state's immunization rate even higher.

PRESIDENT'S LETTER

Private and confidential

Sandra F. Olson, MD



The concept of widespread dissemination of personal medical information can be frightening.

The issue of privacy and confidentiality of patients' medical information has rapidly risen as a priority for federal and state legislatures. As electronic communication of clinical, financial and other information about patients and doctors becomes increasingly widespread, the age-old question of "who needs to know" vs. the "right to privacy" will become more of a focus of intense debate. And that's not all bad. More medical information is reaching more hands, thanks to this electronic age and the growth of large health care organizations, such as HMOs. Information exchange is the basis of the doctor-patient relationship – but if that process is abused, we ask for trouble.

Some patient information may be released for public health reasons without patient consent. For example, a state law recently went into effect that permits a doctor treating an automobile accident victim who is under the influence of drugs or alcohol to release that information to law enforcement personnel. In this instance, the information can be used to compel that person to get treatment. By doing so, we know that there is a good chance the individual will overcome his or her addiction. This law also protects the public by keeping such potentially dangerous drivers off the road.

The Kassebaum-Kennedy Act, passed in 1996, mandates the federal government to address the problem of securing access to electronic patient records. The development and implementation of a process to ensure medical confidentiality was put on a three-year timetable by this federal legislation. A committee appointed by Health and Human Services Secretary Donna Shalala is already at work on this issue. The secretary must make recommendations to Congress regarding safeguards to protect against the unauthorized use or disclosure of patient records. Shalala must report to Congress by August 1997 on implementation of the privacy provisions. Congress then has two years to enact privacy legislation.

By February 1998, standards must be proposed for "a universal health identifier" for each individual, employer, health plan and health care provider. Uniform data standards for health care providers must also be adapted and implemented, and that, too, has a short timetable. Industry must adapt these regulations so that in less than three years, by February 2000, all parties will be able to exchange health data electronically.

The Illinois Legislature has not yet addressed the electronic security of medical data as a single global issue.

A new report by the National Research Council, the research arm of the National Academy of Science, covers such potential problems in electronic record-keeping as the confidentiality of the information used by health care personnel and the protection of data as it moves to outside parties such as third-party payers and employers. The concept of widespread dissemination of personal medical information can be frightening, especially regarding patients with sensitive conditions.

When you consider the number of people who can access the written records of hospitalized patients without documenting that they have looked at those records, it adds up to literally hundreds. Which one of us has not strolled down the corridor, looked at a chart rack, seen a familiar name, and out of concern picked up the chart to find out why a friend, acquaintance or neighbor is in the hospital? This is really not acceptable. There is an important advance, however, that the electronic medical record provides: Safeguards can be built in that will develop an audit trail to identify any person who has accessed the record.

There is no question or argument that medical information must be private and secure. That's the basis of the doctor-patient relationship, the very foundation of good, respectful medical care. Concern about privacy and confidentiality cannot become a barrier to obtaining needed medical care – patients need confidence in the private nature of this bond, and they deserve assurance that their secrets are safe.

GUEST EDITORIAL

Intact dilatation and extraction is bad medicine

By M. LeRoy Sprang, MD

The issue of intact dilatation and extraction (D&X), or partial-birth abortion, came to the attention of the ISMS Board of Trustees in a rather ironic manner. A pro-choice group had asked the Society to consider supporting the procedure and taking its endorsement to the ISMS Board for final approval. Instead, Board members were horrified by the description of the procedure and voted to support a ban.

During intact D&X, the baby is turned in the uterus and the feet are pulled until only the head remains in the uterus. Sharp instruments are inserted blindly into the baby's head, and the brain is suctioned.

Prior to adopting a stance on the



issue, the Board debated the issue in depth: We tried to get past our personal biases. One Board member cited a Sangamon County study showing that 91 percent of local physicians supported a ban on intact D&X. In the end, we determined that intact D&X is simply bad medicine because the procedure has no medical necessity. In fact, the American College of Obstetricians and Gynecologists said in January that there are no circumstances under which this procedure would be the only option to save the mother's life or preserve her health. Many Ob/Gyns and medical professors agree that there are no circumstances that necessitate this procedure. There are other options available.

Beyond the question of medical necessity is the fact that the nature of the procedure imposes significant risks on the mother. In addition, after the procedure is completed, there is the risk of infection, which could cause infertility.

After lengthy discussion, the Board also decided that a ban on this procedure would be appropriate even if legislation included possible criminal penalties against physicians who performed the procedure.

Yes, supporting criminal penalties against physicians is unusual for ISMS, even for a procedure as egregious as intact D&X. Although the Board might have preferred that any such legislation refer physicians to the Illinois Department of Professional Regulation for penalties, we came to the conclusion that criminal penalties against physicians would not be reason enough to oppose a bill.

The Board discussed intact D&X not only to prepare ISMS' legislative position, but to develop a resolution for consideration by the AMA House of Delegates at its interim meeting. AMA delegates discussed Illinois' resolution at length in reference committee. Physicians stood in long lines to voice their opinions, some breaking down in tears as they described the procedure. The AMA House voted to ask a panel of experts to examine the issue. ISMS was invited to participate on and provide input to that panel.

I believe that the reaction of the ISMS Board of Trustees to the issue of intact

D&X is not much different from that of the public. In every study, the overwhelming majority of those polled said they believed this procedure should be outlawed. Many said they didn't understand why such procedures are legal.

Other notable public figures agree with us as well. Former U.S. Surgeon General C. Everett Koop, MD, said, "There is no way that I can twist my mind to say that this procedure is medically necessary, so I am opposed to partial-birth abortion." U.S. Sen. Daniel Patrick Moynihan (D-New York), who is pro-choice, said, "After hearing about this procedure, [I believe] it is as close to infanticide as anything I have come upon."

Two bills banning the procedure, H.B. 382 and S.B. 230, are making their way through the Illinois General Assembly in the next few weeks. It remains to be seen what will occur — whether lawmakers will pass one of them, whether Gov. Edgar would sign it and whether it would be challenged in court.

Intact D&X has no relationship to medical necessity. By allowing this procedure to be performed, we are not saving women's lives, and we are putting mothers at risk of significant medical complications. By endorsing a ban on this procedure, the ISMS Board has taken an important step toward protecting the health of mothers-to-be and their children.

Dr. Sprang is an Evanston Ob/Gyn and chairman of the ISMS Board of Trustees.

GUEST EDITORIAL

MCPRA allows physicians more clinical autonomy

By Susan Schy, MD

Once again, Illinois physicians are watching with interest as a bill crucial to the practice of medicine, the Managed Care Patient Rights Act of 1997, is considered in the state Legislature. MCPRA reflects our concerns about patients' rights and our ability to treat patients with the highest quality of care our medical training makes possible.

Over the years, many of us have experienced or seen health care settings in which profits were more important than our patients' clinical condition. Granted, health care has become increasingly expensive, and there should be checks and balances to ensure that care is cost-effective. But in some systems, cost-effectiveness has eclipsed any concern for the quality of our patients' care.

That concern is addressed by MCPRA, which stresses the physician-patient relationship and the basic rights of patients to choose a physician, to work with that physician and to feel confident that the physician will be medically thoughtful on their behalf instead of administering care based on finances alone.

One critical provision of MCPRA calls for adding medical staffs to managed care plans. This allows physicians to participate in the policy-setting process that is sometimes handled by managed care plan administrators who are businesspeople. In addition, it allows for knowledgeable specialists to be represented on these panels and to give their input into the medical guidelines that govern specialty procedures, which are unique and deserve more than routine consideration. Guidelines and policies — and the written justification for them —

are more meaningful if our colleagues who have similar training and background are our judges.

The solution to our problems is not ineffectual or fragmented legislation. A case in point is the state law concerning maternity length of stay. Most Illinoisans thought the law guaranteed across-the-board insurance coverage of a minimum 48-hour postpartum stay as of last Sept. 15. But the law applies to only about 65 percent of Illinois women, excludes self-insured plans and becomes effective only as policies are issued, amended or renewed.

Federal law mandating insurance coverage for 48- to 96-hour stays doesn't take effect until Jan. 1, 1998. Although patients may think they have insurance coverage for 48 hours of hospitalization, insurance carriers state that they should be able to discharge a "willing and able" patient after only 24 hours, followed by a home nursing visit. Most plans will let physicians evaluate every patient separately and increase the length of stay if a patient's condition demands it.

The strength of the maternity length-of-stay legislation and of MCPRA is the attention paid to patients' clinical needs and the flexibility when individual needs warrant it. The added benefit of MCPRA is that it is comprehensive, addressing quality of care in a multidimensional way rather than in an isolated, piecemeal fashion.

We physicians went to medical school to provide the highest-quality medical care possible. MCPRA will help us keep doing that.

Dr. Schy is an Ob/Gyn in Park Ridge.

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ISMS delegates will debate resolutions

ANNUAL MEETING: Subjects for discussion will include managed care, public health. BY JANE ZENTMYER

[CHICAGO] In about a week, members of the ISMS House of Delegates will debate some new solutions to difficult problems in managed care, public health and professional liability. The House will consider 88 resolutions during its 1997 Annual Meeting to be held from April 18 through April 20 at the Oak Brook Hills Hotel in Oak Brook.

"The House of Delegates is the same as the House of Representatives," said Speaker of the ISMS House Richard Schmidt, MD. Delegates bring physician-developed resolutions to the House, which, if approved, can lead to changes in policies and laws on a local, statewide or national level. Each resolution has been assigned to a reference committee, where it will be discussed by delegates and voting members before being debated and voted on by the full House.

Two main categories of issues — health care economics and governmental affairs—public policy — account for more than half the resolutions submitted, Dr. Schmidt said. Included in those categories are resolutions on Medicare and Medicaid reimbursement and managed care.

Specific managed care topics surfacing this year include credentialing, physician deselection, disclosure of financial incentives to insurers and patient protection under HMO laws. One resolution

encourages ISMS to seek legislative or other means to prohibit managed care plans from requiring physicians to send all specimens to outside labs if performing the tests in an office setting might be more feasible and appropriate.

The public health resolutions include a mandate for public washrooms to display signs encouraging hand-washing. Another resolution urges the develop-



Bernardin Center receives federal grant for cancer cell immortalization research

[MAYWOOD] The National Institutes of Health has awarded a \$1.55 million grant to researchers at the Cardinal Bernardin Cancer Center of Loyola University Medical Center to study cancer cell immortalization.

"The grant will help us find a solution to the problem of cancer cell immortality in hopes that new treatments for cancer will develop," said Manuel Diaz, MD, director of the molecular oncology program at Loyola.

To try to understand why cancer cells can divide forever and allow for the continuous growth of tumors, Dr. Diaz and the members of his research group will focus on the way the molecule P-16

works. In tumor cells, P-16 is either deleted or inactivated, and researchers believe this may be related to the inability of the cancer cells to undergo senescence. By understanding its action and those of the other molecules involved in controlling the overall process, they hope to come up with a strategy that will force cancer cells to undergo automatic death.

One of Dr. Diaz's collaborators, David Peace, MD, assistant professor of medicine at Loyola, said, "Because of the fundamental question that's being addressed in this research, there's a lot of excitement over getting the award. This study is a primary objective of the lab, and to have funding for it is gratifying."

The Medical Practice Act's 50-hour CME requirement led to resolutions this year that ask for the AMA's Physician's Recognition Award to meet the mandate

and to make the requirement advisable but not mandatory for license renewal.

During their three-day stay in Oak Brook, delegates can take a break from their work to attend social events. The ISMS Alliance is inviting delegates, their spouses and guests to a reception from 8:30 to 10 p.m. on April 17. ISMS' President's Night will be held April 18 to honor current ISMS President Sandra Olson, MD.

April 19 will begin with the Public Affairs Breakfast featuring Illinois first lady Brenda Edgar. The Illinois State Medical Society Political Action Committee Annual Meeting will follow the breakfast.

HONORED

for her support in helping ISMS receive commendations as an accreditor of Illinois CME providers, Evelyn Calhoun is the

most recent recipient of ISMS' Employee Recognition Award. She is the education/licensure assistant in ISMS' Division of Education and Accreditation.



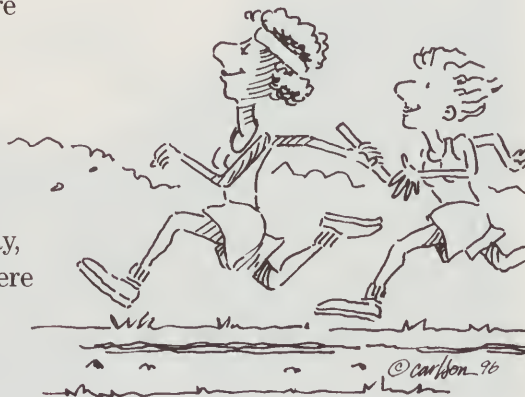
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ISMIE Update

Coming soon:
What you should
know before joining
a managed care
plan

Don't leave town without it

A plan for the on-call physician can prevent problems. BY CHRIS PETRAKOS

The orthopedist applied a cast to the leg of one of his patients, doing as much as he could before leaving for a long-anticipated vacation. Shortly after the physician left town, the patient developed pain severe enough to require medical attention.

After hearing the patient's complaints described over the phone by a friend of the patient, the on-call physician – who did not have specific protocols from the vacationing physician – recommended some practical solutions, such as changing the elevation of the leg and increasing the pain medication. Months later, the on-call doctor, who had never actually seen the patient, found himself in court after the problem worsened to eventually require amputation.

Such tragic incidents can be prevented by having protocols in place. Oak Park pediatrician Sharon Flint, MD, a member of the ISMIE Pediatric Risk Management Subcommittee, said that physicians should turn their practices over to physicians in the same specialty. For example, a pediatrician would want to be covered by a physician who has experience in taking care of children, she explained.

Just as important is the need to inform patients as early as possible that the physician will be leaving town and how to contact the referred physician, said Chicago internist Wesley Gregor, MD, a member of ISMIE's Internal Medicine Risk Management Subcommittee. Some practices offer this information in brochures that outline the practice policies or during new-patient visits. The information must include the referred doctor's name and how he or she can be reached. "I usually tell patients that if there is any problem in reaching a physician and if the situation seems to be urgent, they should just go to the emergency department," Dr. Gregor said.

During rounds, departing physicians should tell their hospital patients who will be caring for them during their absence.



"Billy Halloran's mother called – his temperature is 103, and he's vomiting.... And Mrs. Costigan wants to know if she can renew her prescription...."

It's also a good idea to tell a family member whenever possible, particularly if the patient is confused or heavily medicated, Dr. Gregor said. "A note should also be entered in the patient's

chart, along with the phone number or pager number of the covering physician, so that the hospital personnel know whom to contact," he added.

Following coverage guidelines is especially important when it comes to prescribing medication. It's not unusual for patients to call his group practice after office hours or on weekends to ask for prescriptions, Dr. Gregor said. "Depending on the prescription, I'll usually give them enough for the weekend and then make sure the physician for whom I'm covering knows that it was filled. We have an agreement in our group not to prescribe Schedule II drugs on weekends."

It's imperative for physicians in solo practices, too, to have a medication policy in place, said Martin Bresler, a senior partner

ISMIE offers Loss Prevention Seminars in May

ISMIE has scheduled two free Loss Prevention Seminars in May for all physician specialties. The half-day programs – one in Springfield and the other in Oak Brook – will cover medical record-keeping, communication skills, general loss prevention techniques, legal tips and case presentations.

The Springfield seminar will be held from 8 a.m. to 11 a.m. on Thursday, May 1, at the Hilton Hotel at Seventh and Adams. In Oak Brook, the seminar will be presented from 9 a.m. to noon, on Saturday, May 17, at the Oak Brook Hills Hotel at 3500 Midwest Road.

All ISMIE policyholders are welcome to attend. The seminars are approved for up to three hours of Category 1 CME toward the AMA Physician's Recognition Award. For more information, call the ISMIE Risk Management Division at (312) 782-2749 or (800) 782-4767, ext. 1327.

in the Chicago law firm of Bresler, Harvick and Glenn. He suggested that the on-call doctor should prescribe only enough medication to last the patient until the vacationing doctor is back in town and instruct the patient to see the doctor on his or her return.

Dr. Flint pointed out that

regardless of the type of prescription, good documentation is crucial so that the patient's attending physician knows what has been dispensed. "As a covering physician, I would be reluctant to prescribe antibiotics over the phone to somebody I've never laid eyes on. If it's more-chronic medication, such as for an asthmatic who has run out of medication, that's one thing, but I wouldn't start somebody on a prescription without seeing him or her."

Physicians should also discuss drug preferences with their covering physicians, Bresler said. "Most doctors develop a preference for the use of certain drugs, and the on-call doctor should be made aware of those. The same thing is true for your preferences in referring [patients] under certain circumstances."

Once vacationing physicians have asked a colleague to cover for them, they should provide a list of their patients and, if possible, introduce them to the on-call physician, Bresler said. He also suggested listing high-risk patients – whether they're in or out of the hospital – who need to be followed closely. "Have the charts of those patients already pulled in your office. That way if the on-call doctor needs them, the staff doesn't have to be hunting around for them," Bresler suggested.

On their return, physicians should spend some time talking with the on-call physician about patient contacts and making sure that those contacts have been documented in the files. ■

MALPRACTICE ROUNDUP

Surgeon didn't breach duty by leaving the OR during surgery

The Mississippi Supreme Court ruled that a surgeon who stepped out of an operating room while a certified nurse anesthetist administered anesthetic was not responsible for the patient's injuries due to oxygen deprivation, according to the March 10 edition of the National Law Journal.

In *Starcher vs. Byrne*, the anesthetic was administered by a CNA who worked for the surgeon instead of the regular anesthesiologist. While the CNA was working with the patient, the surgeon left the OR to answer an emergency page. The patient experienced a bronchospasm that deprived her of oxygen long enough to lead to brain damage. The patient sued the surgeon and lost. In her appeal, the patient said the surgeon breached the standard of care by not being present in the OR during the administration of the anesthetic, citing Mississippi standards for nurse anesthetists.

The high court noted that other than the plaintiffs' expert witness, physicians who testified said that physicians had to be present in the surgical suite – not necessarily in the OR – during the induction of anesthetic. The court held that given the evidence, the surgeon had not breached his duty.

Patient with unwanted breast augmentation wins \$1.85 million

A patient who sought only liposuction to remove excess fat from her lower body ended up with breast augmentation surgery as well. After the unwanted surgery and about 20 unsuccessful corrective surgeries left permanent scarring, the patient was awarded more than \$1.85 million in damages, according to the January edition of Medical Litigation Alert.

In *Ross vs. Rosenberg*, the patient claimed the surgeon administered Valium as she was being wheeled to the operating room and told her for the first time that he planned to redeposit the fat removed during the liposuction into her breasts.

The patient maintained that the surgery was done without her informed consent. Her attorney claimed that the procedure was contraindicated and that the patient developed necrotic breast tissue and infection, and the breasts deflated.

Illinois joins nationwide on partial-birth

ISMS' Board of Trustees supports ban on procedure



nurse's eyewitness account of an intact dilatation and extraction (D&X), or partial-birth abortion, compelled Illinois Sen. Chris Lauzen (R-Geneva) to introduce a bill banning the procedure last year.

Lauzen said the nurse described the "fingers clasp and unclasp, the feet kicking, the heartbeat on the monitor and then the startled reaction as the scissors were punctured through the back of the skull."

Lauzen's bill didn't progress because state legislators waited for the U.S. Congress and President Clinton to take action on the issue. When Congress failed to override the president's veto of the ban, Lauzen reintroduced his bill this session. ISMS supports the measure. "I am very grateful to [ISMS]," he said. "I appreciate that the medical profession has stepped forward to get the truth in front of people as they're forming an opinion and as we're making public policy."

In November 1996, the ISMS Board of Trustees took action on the issue by developing a resolution to be considered at the AMA's 1996 interim meeting. The resolution asked that the AMA work "immediately and diligently" to oppose all intact D&X procedures and to establish AMA policy reflecting that action.

"Once the issue came up, [ISMS] Board members started asking questions about the procedure because many people, physicians included, don't really understand or even know much about the procedure," said ISMS Board of Trustees Chairman M. LeRoy Sprang, MD. "As it was described and discussed, most Board members were horrified at the gruesomeness of the procedure."

The AMA House of Delegates debated the Illinois resolution at its meeting and approved a study of the intact D&X issue. The report is being prepared with input from ISMS. It is expected to be presented at the AMA's annual meeting in June, according to an AMA spokesperson.

ISMS Secretary-Treasurer Chester Danehower Jr., MD, said a radio program convinced him to support a ban: "It haunted me. When people really know what this procedure is, I don't think there's any choice but to do away with it."

Some physicians in Sangamon County feel strongly about the issue as well, according to a study conducted by Perry M. Santos, MD, an associate professor of otolaryngology at the Southern Illinois University School of Medicine. The study described the intact D&X procedure and the status of federal legislation. Ninety-one percent of the responding physicians said they agreed with the proposed effort to outlaw the procedure.

On your behalf

The issue of intact dilatation and extraction (D&X) first went before ISMS' Board Trustees in November 1996. The Board members asked questions about the procedure, and as it was described, they "were horrified," according to ISMS Chairman of the Board of Trustees M. LeRoy Sprang, MD. After discussion, the Board approved a resolution urging the AMA to "immediately and diligently" oppose all intact D&X procedures and to establish AMA policy reflecting that action.

The AMA House of Delegates debated the issue at its last interim meeting and approved a study of the intact D&X issue. ISMS is providing input into the study report, which will be presented at the AMA's annual meeting in June.

The response exceeded Dr. Santos' expectations: Some 35 percent of the physicians polled returned completed surveys. In addition, 114 respondents agreed to publicly oppose intact D&X procedures by having their names printed in a Springfield newspaper, with some even offering to help pay for the ad, Dr. Santos said.

"In general, you don't get very many responses back from any survey, but especially not doctors," said ISMS President-elect Jane Jackman, MD. "I was amazed that he got back so many responses. That indicates to me that most doctors, at least in Sangamon County, have very strong feelings about partial-birth abortion."

As part of its action in November, the ISMS Board voted to support proposed state legislation even if it imposed criminal penalties on physicians who performed intact D&X. Dr. Sprang explained that the support was based on "the egregiousness of the procedure." Although Board members might have preferred not to link criminal penalties with a ban, they would not oppose a bill on the basis of inclusion of criminal penalties.

In general, ISMS opposes criminal penalties related to medical procedures, Dr. Sprang said. But in this case, intact dilatation and extraction "is so gruesome, brutal and inhumane that the Board felt that even [the inclusion of] criminal penalties [in legislation] would not be a sufficient reason to oppose legislation

(Continued on page 10)

debate

with abortion

Organized medicine corrects misinformation

T

he public may have been surprised about revelations that abortion rights supporters underestimated the number of partial-birth abortions performed and the pre-abortion health of the mothers and fetuses. But the AM News reporter who

broke the story said she knew from the start that the published numbers and information were misleading.

Reporter Diane Gianelli's first story about intact dilatation and extraction (D&X) was published during the summer of 1993. As part of her research, Gianelli interviewed the two physicians credited individually for developing the procedure – Martin Haskell, MD, from Dayton, Ohio, and James T. McMahon, MD, who is now dead. "I found them to be very direct and candid and willing to talk," she said. "[They] just gave me, and subsequently my readers, a really good look at what they do, why they do it and the circumstances under which women come to them."

In interviews with AM News in 1993, Dr. Haskell said he performed abortions "up until about 25 weeks" of gestation, most of them elective, and Dr. McMahon said he performed the procedure throughout all 40 weeks of pregnancy. Dr. McMahon said at the time that he wouldn't do an elective procedure after 26 weeks. About 80 percent of those he did after 21 weeks were nonelective, Dr. McMahon said.

Dr. Haskell also told AM News in 1993 that whatever qualms he had about third-trimester abortions were "only for technical reasons, not for emotional reasons of fetal development." He added that he didn't view himself as a "trailblazer or activist trying to constantly press the limits."

"[The doctors] were very willing to talk and set the record straight," Gianelli said. The media tend to rely on information presented by either side of the debate instead of information from original sources, such as the physicians, and therefore risk perpetuating skewed information, she added.

When federal legislation proposing a ban was introduced in 1995, the procedure again became the subject of controversy, with abortion rights supporters and the media underestimating the number of procedures performed annually and the health of mothers and fetuses prior to the procedure.

Gianelli's stories were corroborated by Ron Fitzsimmons, executive director of the National Coalition of Abortion Providers. According to the March 21 edition of the New York Times, Fitzsimmons came forward in February and told ABC's "Nightline" that he had lied by underestimating the number of partial-birth abortions performed each year. Fitzsimmons said in a statement that was never broadcast that several thousand partial-birth abortions were performed yearly, not several hundred, as he had previously told the media.

When the federal bill came up for a vote last year, Fitzsimmons called members of his coalition and found that the vast majority of intact D&X procedures were done on healthy fetuses and mothers in

their 20-plus weeks of pregnancy, according to the March 3 issue of AM News. "The abortion rights folks know it, the anti-abortion folks know it, and so, probably, does everyone else," Fitzsimmons told AM News. He also said the ban wasn't worth "going to the mat on" and, if enacted, would have very little real-world impact on physicians and patients."

Although media accounts of last year's debate estimated that 500 or 600 intact D&X procedures were performed in the United States annually, AM News reported the figure to be in the thousands.

Although intact D&X isn't the only procedure by which late-term abortions are performed, the number of late-term abortions has also generated controversy. The Chicago facility of the Planned Parenthood/Chicago Area said it generally does not perform abortions past 14 weeks, according to Jenny Cheek, the group's director of public affairs.

"What seems to be the main result of [media coverage is] that the focus has shifted from women needing a medical procedure to who said what and how many of what is done in the United States every year," Cheek said. "We're really hoping to show lawmakers both in the state of Illinois and at the federal level that what's really important is protecting women. This issue of numbers is less important."

Numbers do show, however, that late-term abortions are being done in Illinois and nationwide. A

(Continued on page 10)

Fitzsimmons said that several thousand partial-birth abortions were performed yearly, not several hundred, as he had previously told the media.

ISMS supports

(Continued from page 8)

banning the procedure." Last year, the AMA supported federal immigration legislation that included criminal penalties for performing female genital mutilation. The act passed Congress and was signed by the president in 1996, and became effective on April 1. The AMA's support developed from policy that was expanded at its June 1996 annual meeting.

Illinois measures S.B. 230 and H.B. 382 are identical and would create the Partial-Birth Abortion Ban Act, equating the procedure with a Class 4 felony. The

bills define partial-birth abortion as a procedure "in which the person performing the abortion partially vaginally delivers a living human fetus or infant before killing the fetus or infant and completing the delivery."

S.B. 230, Lauzen's bill, passed the Senate on March 18, with 44 senators voting for the bill, seven against it, and five voting present. The House bill, whose lead sponsor is Rep. Peter Roskam (R-Wheaton), passed out of the House Executive Committee with a 10-0 vote and seven representatives voting present.

The bills allow for exceptions if intact

D&X is necessary to save the mother's life because of a physical disorder, physical illness or physical injury. Exceptions also include life-endangering conditions caused by or arising from the pregnancy itself, provided that no other medical procedure would suffice. Women who underwent intact D&X would not be subject to prosecution under the measures.

The American College of Obstetricians and Gynecologists opposes a federal ban on intact D&X, according to ACOG President Fredric Frigoletto, MD. He said ACOG is concerned that some components of intact D&X are used in other established obstetric procedures,

and the ban might extend to other procedures and "outlaw them." Dr. Frigoletto added that "the other side has strategically picked on a procedure. The alternative procedures are equally 'demonizable.'"

Dr. Sprang said that a recent ACOG executive board policy statement acknowledged the problem with the procedure. The statement says, "A select panel convened by ACOG could identify no circumstances under which this procedure, as defined above, would be the only option to save the life or preserve the health of the woman." But the ACOG statement goes on to defend the procedure, Dr. Sprang said. According to the statement, "An intact D&X, however, may be the best or most appropriate procedure in a particular circumstance to save the life or preserve the health of a woman, and only the doctor, in consultation with the patient, based upon the woman's particular circumstances can make this decision. The potential exists that legislation prohibiting specific medical practices, such as intact D&X, may outlaw techniques that are critical to the lives and health of American women. The intervention of legislative bodies into medical decision-making is inappropriate, ill-advised and dangerous."

Dr. Sprang said that intact D&X is never medically necessary and that the issue does require government intervention. "We are all in favor of independence and autonomy. [But] there are checks and balances in society. Government does have a role to play." He added that a ban wouldn't preclude the use of other procedures to protect women.

A letter to Dr. Frigoletto from the Physicians' Ad Hoc Coalition for Truth said that intact D&X is not medically recognized. "ACOG agrees that there are other medically recognized and standard procedures available to women other than partial-birth abortion. Given ACOG's acceptance of this medical fact, your claim that a totally unrecognized nonstandard procedure, for which no peer-reviewed data exist, can nonetheless be the safest and most appropriate in certain situations simply defies understanding. When the medical decision-making itself is inappropriate and may be putting women at risk by subjecting them to medically unrecognized procedures, the intervention of a legislative body may be the only way to protect mothers and infants threatened by the partial-birth abortion procedure." ■

Organized medicine

(Continued from page 9)

story in the March 23 edition of the Chicago Tribune said the Hope Clinic in Belleville is one of the few clinics in the Midwest that will perform abortions on women who are up to 24 weeks' pregnant. In 1996, 6,848 abortions were performed there, including 1,233 that were done on women who were 14 to 24 weeks pregnant. The clinic doesn't use intact D&X, though, according to the Tribune.

In 1994, a total of 1,267,415 legal induced abortions were reported to the U.S. Centers for Disease Control and Prevention. Of those, about 55,900 were done in the 16th to 20th week of gestation, and about 16,900 were performed after 20 weeks, according to the CDC's preliminary figures. ■

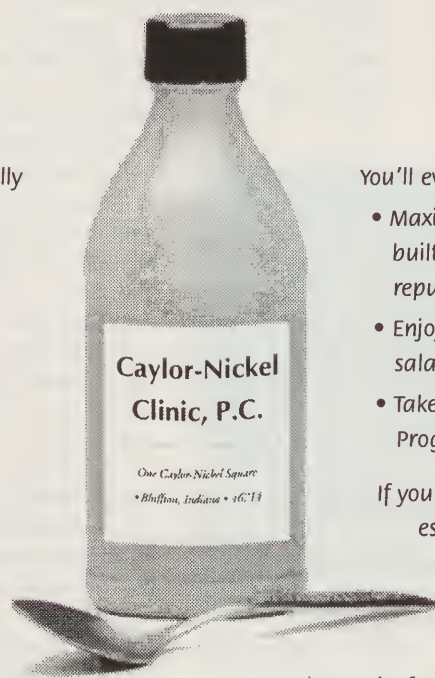
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Managed care reforms

(Continued from page 1)

cy, testified on the AMA's patient advocacy project and its research on gag clauses: "It involved reviewing more than 200 managed care contracts — many of the contracts from the state of Illinois — and interviewing hundreds of physicians, patients and attorneys in Illinois and across the country.

"This process was very long and arduous," she continued, "but in retrospect I'm thankful that we took on this project because without this information we would have no idea of some of the truly



O'Brien

shocking and widespread practices occurring in today's health care environment due to a lack of meaningful regulation. Nor would we have learned that our traditional legal remedies have not kept pace with the transformation of health care into a for-profit and managed care environment."

Gag clauses come in many forms, O'Brien said. For instance, a "termination without cause" provision in con-

tracts allows insurers to dismiss physicians from plans for any reason at any time. Some plans use "anti-disparagement" clauses that require physicians to "make no communication to patients that could tend to undermine their confidence in the plan." The AMA has affidavits signed by physicians that document how gag clauses can lead to termination when physicians ignore the clauses and advise patients of expensive treatments or tests the plan doesn't cover.

"It is important to note that gag policies are clandestine and often carried out in approaches that are not clearly laid out in contracts," O'Brien explained.

"These approaches range from medical directors orally admonishing physicians not to tell patients about expensive treatment options, writing threatening notes in a patient's medical record or issuing a policy or bulletin that is not contained in any official plan document or contract."

Plans often don't allow physicians to do any meaningful contract negotiation, O'Brien said. And physicians know that if they negotiate aggressively, plans might disapprove the contract or terminate an existing contract prematurely.

Narrowly focused legislation that would eliminate contractual gag rules and plan actions that gag physicians isn't the way to guarantee patient rights, O'Brien said. "As important as the patient's right to medical information and full and informed consent is, a piecemeal approach is not going to serve to fully protect patient rights. A system of reasonable, comprehensive reforms and remedies is needed for all plans in order to protect Illinois patients and to promote the long-term integrity of the Illinois health care system."

IN ADDITION TO MCPRA, other bills that propose managed care reforms are pending in the General Assembly. Rep. Mary Flowers (D-Chicago), chairman of the House Health Care Access and Availability Committee, introduced a bill that is similar to one passed in New York. The New York measure addresses disclosure to enrollees, standards for handling grievances, procedures for terminating health care professionals, standards and procedures for determining whether services are covered and time frames for making utilization review decisions.

Flowers' bill, H.B. 626, also called the Managed Care Reform Act, would require plans to disclose specific information, would establish grievance procedures and an independent external review, would allow public hearings for termination of physician contracts and would require plans to report to disciplinary agencies. The bill is also on the House floor.

At one of the committee hearings, Flowers said her bill would be used as a vehicle that would be reworked to incorporate input — and generate support — from all or at least most of the interested parties.

The Illinois Association of Health Maintenance Organizations has also introduced its own limited version of managed care reform. In a Feb. 27 news release, IAHO President Barbara Hill said the bill would ban gag clauses in Illinois even though the group doesn't know of any contracts containing such clauses. "Technically, we don't need a law banning something that's not happening — but by putting it into law, it will give consumers and physicians peace of mind."

O'Brien pointed out, however, that IAHO's H.B. 1042, unlike MCPRA, disallows only some gag policies. "This bill would not allow a physician, for example, to discuss arrangements for continuity of patient care in the event the physician [contract] was terminated," O'Brien said. "Nor would it allow physicians to answer questions from patients or discuss financial arrangements." IAHO's bill is also pending on the House floor.

Illinois Medicine will cover other pending managed care reform bills in upcoming issues.

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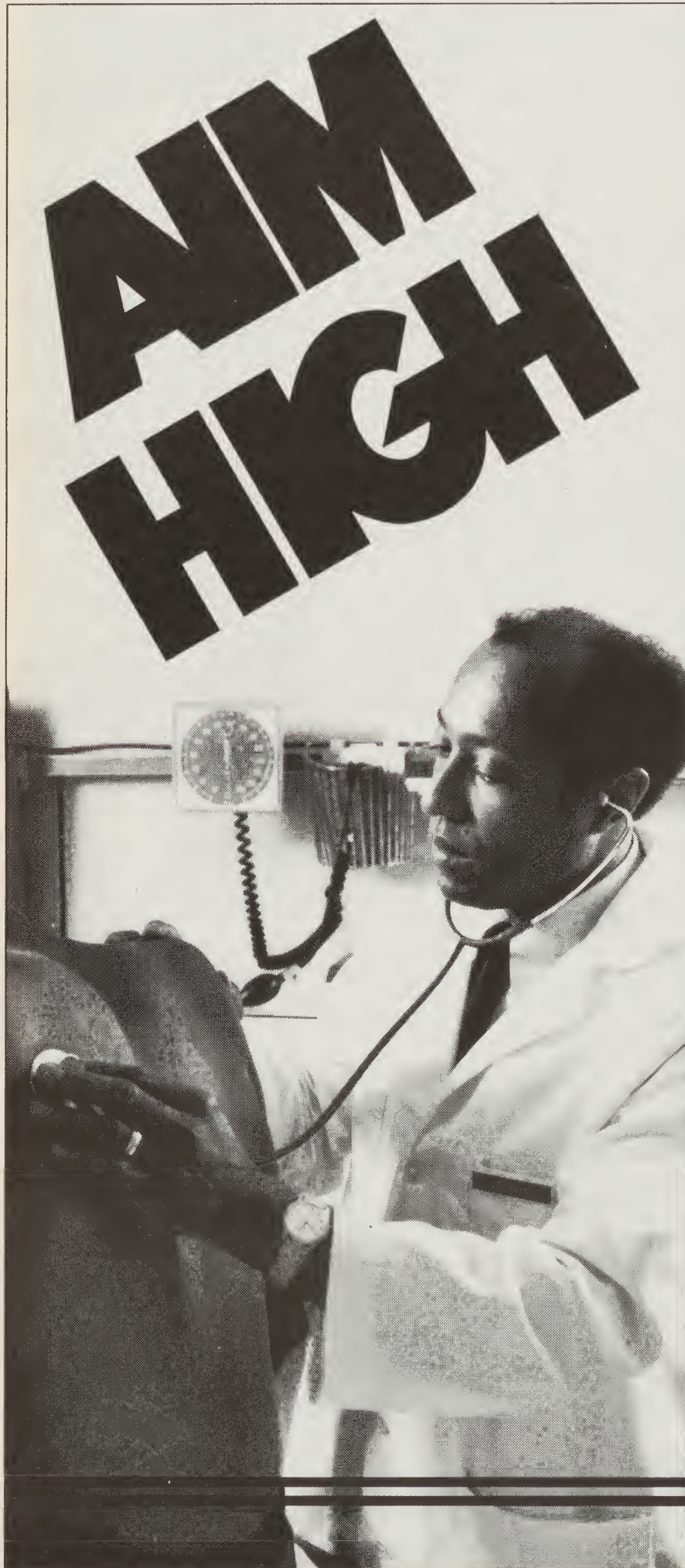
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Mini-internships

(Continued from page 1)

work entails. This gives them some firsthand knowledge. Most of them have been surprised at the varied activities that we do over the course of a day."

That was particularly true for Ayers, who is a trustee for his union's welfare trust fund. He pointed out, that as a major health care purchaser, he was amazed at the support staff needed to run a medical office. "When you go in for a checkup, you typically see the doctor and the nurse. But you don't see all the support staff, who clearly outnumber the medical staff – the lab people, the insurance people, the records people. People get the impression that doctors are overpaid or that their fees are too high. But when you start looking objectively at the kind of costs they incur, you realize that it takes money to get quality care. And to get quality care you have to have all this support."

I had this false impression that doctors had a pretty cushy life.

ISMS and ISMSA began the mini-internship program in 1991 to help educate local policymakers and shape the public's opinion of medicine. This year, interns from eight Illinois counties have participated in the program. ISMSA Legislative Chairman Pam Taylor said that legislators and businesspeople have responded positively and that relationships begun that day often last longer. Physicians and the coordinators from the county medical societies become valuable resources when policymakers need to find out how proposed legislation might affect physicians and medical consumers, she said.

Taylor explained that it takes about four months – and considerable legwork – to ensure that community members get a productive view of medicine during their day-long internships. "There have to be two coordinators for every intern in case one gets sick. Both coordinators have to be capable of taking the intern and continuing with him or her in case something comes up and [the intern isn't] able to accompany the doctor. It's a big responsibility."

But it's a responsibility that pays off. Rep. Doug Scott (D-Rockford), has gone through the program twice, the first time with an anesthesiologist and most recently with Richard Wieder, MD, a Rockford ophthalmologist. Spending the day in Dr. Wieder's office, Scott saw a variety of medical issues, from youngsters being checked for school to patients with severe problems.

"It's a very enjoyable day, very informative," Scott said. "There is so much on our plate right now in terms of health care. I was intrigued and surprised by all the different forms Dr. Wieder had to fill out, just the sheer amount of paperwork involved. It's very helpful to see what's going on – not only for legislators, but for businesspeople who are purchasing health care."

Ayers said his health and welfare fund provides insurance for 27,000 people. "Typically, we have two or three meetings a year into which we try to cram all our business. Of course, our fund attorney and fund consultant are present. Until now, I've always had the impression that the consultants were giving us the perspectives of the medical profession. We hadn't been getting the true story, and that's important for somebody like myself who is spending \$50 million to \$70 million a year. What I got from that day with the doctor is that we should be communicating with doctors and not with consultants." ■

APOLLO 13 ASTRONAUT

Capt. James Lovell Jr. (left) shares a laugh with Kenneth Janson, MD (right), and Vandy Janson at the Lake County Medical Society and Lake County Bar Association annual combined meeting in Highland Park on March 11.



Chip Zeliet

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Managed care contracts raise new legal issues

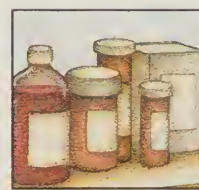
PAGE 6

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PAGE 7

Managed care bills accumulate on General Assembly's agenda

OUTLOOK: Lawmakers have their hands full of potential reforms. BY JANE ZENTMYER

[SPRINGFIELD] Physicians should know by the General Assembly's May 23 adjournment date whether any of the 30-plus pending managed care reform bills have found their way to Gov. Jim Edgar's desk. Some of those bills take a piecemeal approach to reforming managed care, and others, like the ISMS-developed Managed Care Patient Rights Act, are more comprehensive.

Rep. Carolyn Krause (R-Mount Prospect) talked about the prospect of passage of a comprehensive managed care bill. "Very clearly our constituents are looking for the legislators to proceed in [a comprehensive] way, and in the next two months we're really going to be able to tell if we're able

to. I think the time has come to do that."

The House's Health Care Availability and Access Committee conducted subject matter hearings in February and March and eventually sent several bills to the House for discussion and a vote.

The Illinois Senate plans to hold hearings, but the schedule is still pending, said Sen. Tom Walsh (R-Westchester), chairman of the Senate subcommittee that will consider managed care reform. "This could very well go on after session and into the veto session," he said. "We'll just have to see how things go once we begin hearing testimony." He noted that senators would probably use one bill as a vehicle for man-

aged care reform. "It won't be any of the bills that were sent to the subcommittee," Walsh said.

MCPRA, which establishes that patients are entitled to

quality, choice, individual respect, advocacy and information from insurers, is one of the bills awaiting a vote by the House. It advanced from com-

(Continued on page 11)



Terry Farmer

HOLDING UP A RECENT cover story, Springfield radiologist Lisa Wichter, MD, talks about the need for regular mammograms. She joined other panelists including ISMS President Sandra Olson, MD, to discuss health care and managed care at the April 10 Illinois Women in Government seminar in Springfield.

Committee seeks physician input on legal discovery

STATE LAW: Judicial group will recommend changes in rules governing civil litigation. BY JANE ZENTMYER

[CHICAGO] Most Illinois physicians experience the state court system's discovery procedures first-hand at some point during their medical careers. The contacts could come through requests for patients' medical records, subpoenas for depositions in personal injury cases or medical malpractice lawsuits. Regardless of whether those interactions were positive or negative, a committee of judges is seeking information about them.

That eight-member Committee on Discovery Procedures is part of the Illinois Judicial Conference, which was created by the Illinois Supreme Court in 1953 to maintain a well-informed judiciary and improve the administration of justice, according to the conference's 1993 report. This particular conference committee has been

asked to propose changes to the rules governing the discovery process for civil lawsuits. The state Supreme Court will make the final decision on the committee's proposal.

"We want to explore and get input from the medical profession regarding problems they experience in connection with civil litigation," said Dale Cini, chairman of the Committee on Discovery Procedures and an Illinois circuit court judge. "We don't want to ask lawyers to tell us what the problems are. We want doctors to tell us what the problems are."

The committee is looking for physicians' experiences that relate to discovery procedures, Cini explained. Black's Law Dictionary defines discovery as the stage when defendants disclose facts, titles, documents or

(Continued on page 8)

INSIDE

**House considers
ban on genetic
discrimination**



PAGE 3

**How far
will hospitals go
in cost-cutting?**



PAGE 5

DEPARTMENTS

**Malpractice
Roundup.....6**

Classifieds9

Two ISMS-supported bills pass Illinois House

Legislators in the Illinois House debated the merits of two ISMS-supported bills the second week in April and voted to send both to the Senate. One bans partial-birth abortion, or intact dilatation and extraction (D&X), and another establishes mental health parity in insurance coverage.

Rep. Peter Roskam (R-Wheaton) was the lead sponsor of H.B. 382, which would ban intact D&X. With bipartisan support and more than 35 sponsors, the bill passed by a margin of 74-37, with four legislators voting present, on April 11. The Illinois Senate passed an identical bill on March 18.

The bills define intact D&X as a procedure during which a living human fetus or infant is partially vaginally delivered before the abortion is completed. The only exception to the ban would be to save women whose lives were endangered by "a physical disorder, a physical illness or a physical injury, including a condition caused by or arising from the pregnancy itself, provided that no oth-

er medical procedure would suffice for that purpose."

A third bill to ban the procedure, H.B. 1812, would expand exceptions, such as the need to preserve a woman's health.

The House passed H.B. 111, which would require insurance companies to cover mental illnesses under the same terms as other illnesses. The federal Kassebaum-Kennedy legislation includes some mental health parity provisions, but state legislation would help fill in some holes in the federal law, according to members of the Illinois Coalition to Stop Insurance Redlining of Mental Illness.

The bill mandates coverage for serious mental illnesses caused by biological or physiological brain disorders or psychosocial factors limiting patients' ability to function. Depression, bipolar disorders and panic disorders would be covered, but such "life problems" as divorce and job loss would not.

Rep. Lauren Beth Gash (D-Deerfield) was the bill's lead sponsor. The House passed the measure on April 10 by a vote of 82-34.

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ISMIE reaches out to physician policyholders

Outreach Program extends physician ownership by sending doctors to answer questions about ISMIE coverage. BY JANE ZENTMYER

As a physician-owned, physician-run company, ISMIE keeps in touch with its physician policyholders by meeting with them face-to-face whenever possible. "The Outreach Program enables us to speak to our policyholders directly, pick up their concerns and address them on the spot," said Harold Jensen, MD, chairman of the ISMIE Board of Governors.

In September 1992 the ISMIE Board of Governors launched the Outreach Program and the Physician-First Service initiative – a company-wide philosophy of placing policyholders as the top priority in every aspect of company operation. "The company is based on the concept that the policyholders are the boss," Dr. Jensen explained. The Outreach Program extends physician ownership by sending ISMIE Board members, who are also physician policyholders, to meet with policyholders at the local level who have questions about their ISMIE coverage.

The company is based on the concept that the policyholders are the boss.

Dr. Jensen said he gave a presentation to a group of physicians who didn't understand the rationale behind their rating. With help from ISMIE's Underwriting Division, the presentation provided data and explained exactly how the rating was developed. "We'll talk to anybody and be happy to do so," Dr. Jensen said.

A presentation to a urology group in Chicago, for example, might focus on how ISMIE rates and reviews urologists, what the specialty's loss experience is in Cook County and statewide, and how urology compares with other specialties in similar risk categories.

With outreach coordinators arranging the presentations and planning ISMIE exhibits – and input from ISMIE's claims, underwriting, internal audit and risk management divisions – the Outreach Program draws on all ISMIE's resources. The outreach coordinators also stay in regular contact with specialty societies, county medical societies, medical staff secretaries, medical group managers and residency program directors so

that ISMIE stays well-informed of potential concerns related to a particular geographic area or specialty.

An important link in the program is the ISMIE Network. Formed in the mid-1980s, the network creates another way for ISMIE to communicate with its policyholders. Physicians at local hospitals volunteer their time to become the "eyes and ears" of the ISMIE Network, Dr. Jensen explained. Their responsibilities include maintaining an awareness of ISMIE products and programs and helping their local colleagues keep up-to-date. As the representatives hear about problems or concerns, they contact ISMIE so the company can address them promptly. Members of the Board of Governors recommend physicians to become network representatives, and currently 167 physicians represent ISMIE at 160 Illinois hospitals.

"As new matters come up or information needs to be disseminated, we try to give the network representatives some lead time so they'll get the information first, and we try to help them become more visible on the medical staff as resource people," said Boyd McCracken, MD, past chairman of ISMIE's Policyholder Services Committee, which oversees the network. Network representatives may contact ISMIE with problems and questions related to "malpractice insurance generally or their ISMIE policy in particular."

Tim Sullivan, MD, an ophthalmologist from Sterling, said his work as a network representative doesn't take much time away from his practice. "A couple

of the insureds have called when they've had potential problems," he said, adding that he referred the callers to the people they needed to contact at ISMIE. He said the physicians probably called him first because "possibly they felt more at ease."

Through network representatives and Board member presentations, ISMIE tries to make policyholders' contact with their insurance company as easy as possible. And with the changes occurring in the medical marketplace, those contacts help ISMIE stay abreast of physicians' needs, Dr. McCracken said. "ISMIE is very sensitive to, alert to and aware of the need for constant change to meet the needs of the physician." ■

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BETH FINE DISCUSSES THE ethics of genetic counseling at a seminar on the social implications of research held April 8 at the University of Illinois at Chicago. Fine is the genetic counseling program coordinator at the Northwestern University Medical School.

Tuberculosis hits all-time low in Chicago

[CHICAGO] The number of new tuberculosis cases in Chicago fell to an all-time low of 592 in 1996, down 15 percent from 1995 and down 25 percent from 1993, according to the Chicago Department of Public Health. The previous low, 649 cases, was recorded in 1987.

In Illinois, 1,060 cases of TB were reported in 1996, and 1,024 in 1995, according to the Illinois Department of Public Health.

The potentially deadly lung disease made a resurgence in Chicago from 1987 to 1993, fueled primarily by the AIDS epidemic, according to CDPH.

"This downward trend in tuberculosis in Chicago is a credit to everyone who has worked so hard over the years," said

Board of Health President Whitney Addington, MD. "Yet TB remains a concern in Chicago. Let no one suggest that our recent drop in cases is evidence that this public health problem is solved. Any complacency at this point, any lessening of our commitment of resources, will almost certainly lead to an upswing in cases."

CDPH attributed the new low to the city's aggressive use of directly observed therapy (DOT), whereby patients with active TB take their medication under the oversight of health care workers, said a CDPH spokesperson. Health care workers accommodate patients by meeting them at home, at work, at clinics or even in restaurants.

"DOT is a low-tech strategy, but it works," said Paul Williams, medical director at the CDPH Tuberculosis Control Program. "Most people on effective therapy start to feel better in a week or two, but to be cured they need to be on medication for at least six months. On their own they lose interest in taking the medicine, but with DOT, they continue to get it. This brings down the TB rate, which is a big cost savings."

When self-administered, TB medicines must be taken daily. But in DOT programs, medicines are given twice a week, which saves more money, Williams said.

DOT became the city health department's full-time strategy in mid-1993. Before that, CDPH targeted patients who were at the greatest risk of failing to take all their medications, said Commissioner Sheila Lyne.

"Our data indicated that about half of all TB patients in the city were not finishing their treatments," Lyne said. "DOT is labor-intensive and costly up front, but the numbers we are reporting today speak for themselves."

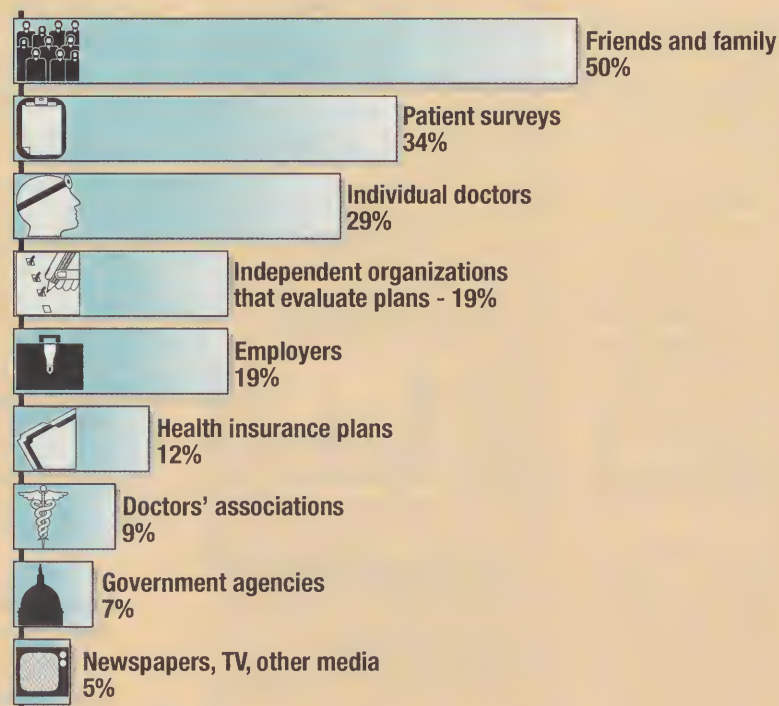
CDPH officials estimate that the use of DOT has prevented more than 550 cases of TB in Chicago since 1994. About two-thirds of all Chicago TB patients are hospitalized at diagnosis, with an average hospital bill of more than \$20,000 each, according to CDPH.

ISMS' House of Delegates supports efforts to promote physician awareness of all current TB control measures. ■

PHYSICIAN FACTS

Where patients want to go for information about health care quality

Sources cited as very believable



Sources: Kaiser Family Foundation and Agency for Health Care Policy and Research, October 1996

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Illinois House considers ban on genetic discrimination

ADVOCACY: Measure prohibits use of test results as basis for employment and insurance coverage decisions. BY JANE ZENTMYER

[SPRINGFIELD] When researchers identified the gene for ovarian cancer last year, Knoxville resident Carolyn Dean prepared to be tested. Both her mother and grandmother died from ovarian cancer, and she had already survived third-stage ovarian cancer more than 10 years ago.

Her family planned for the outcome. Her two daughters decided that if the gene was found in Dean's system, they would be tested. If they carried the gene, both planned to have their ovaries removed as a preventive measure, she said. But then Dean visited her oncologist. "He told me not to be tested because of the discrimination in both health and life insurance – that it would not only affect my immediate family [but] my sisters," she recalled.

Dean was tested anonymously and found that she didn't have the gene. But by the time she had received the results, she had already told her story to Rep. Donald Moffitt (R-Galesburg). He introduced H.B. 8 into the Illinois House to help make genetic information confidential. "If you know you're carrying the gene that puts you at risk, [the bill would] allow you to work very closely with your doctor to do everything you can to help lower your risk and to be extremely active on early detection," Moffitt said.

H.B. 8 and its Senate counterpart, S.B. 672, would prohibit insurers from using information taken from genetic tests in determining accident and health insurance coverage. Insurers would be allowed to use genetic test results only if the individual voluntarily submitted them and the results were favorable. The bills also direct employers to follow federal laws, including the Americans with Disabilities Act, when using genetic testing information.

The insurance industry opposes such legislation, citing the cost of knowingly insuring higher-risk individuals. "The ultimate effect of this well-intended piece of legislation would be to increase the costs to consumers, and as such, it would make it more difficult for them to afford health insurance," said Richard Coorsh, spokesperson for the Health Insurance Association of America, based in Washington, D.C.

ISMS supports both bills, which are pending in the House. The Senate approved S.B. 672, sponsored by Sen. Carl Hawkinson (R-Galesburg), on March 20 and sent it to the House for consideration. H.B. 8 passed out of the Judiciary Committee in February and is still awaiting a vote by the full House.

Hawkinson said he and Moffitt worked with such groups as law enforcement officers to address their concerns. According to the bills, when biological samples are legally obtained for a criminal investigation or prosecution, genetic testing results can be used for identification and can be disclosed to law enforcement authorities in charge of the investigation or prosecution. That disclosure can be given without the individual's consent and can be admissible as evidence in court.

The bills would not create a legal duty or obligation for physicians to reveal the

test results to spouses or legal guardians. In addition, no civil liability or criminal sanctions could be imposed on physicians acting in good faith, whether or not doctors disclosed results to spouses.

Deciding whether to be tested is tough enough for patients and their immediate

and extended families, said Stephen Sener, MD, the head of the general surgery division at Evanston Hospital. But the decision becomes harder with the prospect of genetic discrimination from insurers and employers. If passed, the bills would ease the discussions physicians have with their patients about the pros and cons of genetic testing, he said. "In some cases, [legislative protection] will make the difference between testing and not testing given my experience with these patients."

Other states have considered this issue, and at least 13 have acted on it, according to the National Conference of State Legislatures.

The AMA's Council on Ethical and Judicial Affairs developed guidelines for genetic testing, which are included in its 1997 version of the AMA Code of Medical Ethics. The guidelines address testing by employers and insurance carriers as well as appropriate physician involvement.

Physicians, according to the code, should not participate in genetic testing by health insurance companies to predict a person's predisposition for a disease. Maintaining separate files for the test results may be necessary to ensure they are not sent to insurance companies when fulfilling requests for patients' medical records. ■



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EPORT for Illinois Physicians

MEDICARE PART B NEW NATIONAL COVERAGE POLICY

Electrostimulation in the Treatment of Wounds - NOT COVERED

Electrical stimulation (ES) has been used or studied for many different applications, one of which is accelerating wound healing. The types of ES used for healing chronic venous and arterial wounds, and pressure ulcers are: direct current (DC), alternating current (AC), pulsed current (PC), pulsed electromagnetic induction (PEMI), and spinal cord stimulation (SCS). An example of AC is transcutaneous electrical stimulation (TENS). The PEMI includes Pulsed Electromagnetic Field (PEMF) and Pulsed Electromagnetic Energy (PEE) using pulsed radio frequency energy, both of which are non-thermal i.e., they do not produce heat. Some ES use generators to create energy in the radio frequency band, delivered in megahertz (MHz). They typically deliver energy by contacting means such as coils, rather than by leads or surface electrodes.

There is insufficient evidence to determine any clinically significant differences in healing rates. Therefore, ES cannot be covered by Medicare because its effectiveness has not been adequately demonstrated.

Intrapulmonary Percussive Ventilator (IPV) - NOT COVERED

IPV is a mechanized form of chest physical therapy. Instead of a therapist clapping or slapping the patient's chest wall, the IPV delivers mini-bursts (more than 200 per minute) of respiratory gasses to the lungs via a mouthpiece. Its intended purpose is to mobilize endobronchial secretions and diffuse patchy atelectasis. The patient controls variables such as inspiratory time, peak pressure and delivery rates.

Studies do not demonstrate any advantage of IPV over that achieved with good pulmonary care in the hospital environment and there are no studies in the home setting. There are no data to support the effectiveness of the device. Therefore, IPV in the home setting is not covered.

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EDITORIAL

Read before you sign

Wouldn't it be great if after making a major purchase, you could decide that the item should have cost less and just reduce your payments arbitrarily? At least one multiproduct insurer operating in Illinois is doing something similar with physician reimbursement. The insurer informed physicians that it's changing the existing fee schedules for all noncapitated services the doctors provide, regardless of the product category. That means, of course, that some physicians can expect to see unanticipated cuts in reimbursement. The insurer doesn't need to renegotiate contracts because the changes it's making are in accordance with current physician contracts.

Unilateral contract amendments aren't the only challenges to physician reimbursement. AM News reported on a Chicago otolaryngologist who found out that some of his insurance payments had come with "explanation of benefit" forms stating that those patients were entitled to preferred provider organization discounts. So, the physician cut his payment. But the strange thing was that those patients had regular indemnity coverage. When the doctor checked into the situation, he found that in some cases he didn't even have a contract with the PPO he was discounting, and in others, he was affiliated with the PPO, but the patient wasn't. The doctor was a victim of "silent PPOs."

A silent PPO begins with a payer that contacts a broker who has a list of physicians and discount levels for several PPOs. The payer learns that the physicians are under contract with one PPO for a discount of, say, 25 percent. The payer then recalculates the bill for a particular patient, reducing it by 25 percent to reflect the PPO's discount. But the patient isn't covered by that PPO.

Fortunately, the otolaryngologist caught the problem. But many practices don't have a system for comparing patients' insurance information with the insurers' explanations of benefits demanding patient discounts. As a result, they're losing money. In fact the AMA and the American Hospital Association estimated that physicians could be losing tens of thousands of dollars.

Doctors should beware of PPO contracts that permit the sale of discount information and audit their practices to find out whether PPO discounts are being applied inappropriately, according to the AMA. And physicians can avoid problems with silent PPOs and unilateral contract amendments by scrutinizing their contracts before signing or asking their attorneys to check them.

To help ISMS members steer clear of contract snags, the Society developed the handbook "Before You Sign - A Physician's Guide to Provider Contracts." Members can get a free copy by calling (312) 782-1654 or (800) 782-ISMS, ext. 1131.

PRESIDENT'S LETTER

Thanks for the memories

Sandra F. Olson, MD



All in all, this year was an unparalleled opportunity to grow, learn and experience new opportunities.

The great comedian Bob Hope usually ended his road shows by warbling this tune and recalling some memorable experiences from those trips, especially his holiday visits with GIs. His wrap-up seemed to impart a soothing sense of satisfaction that made you feel these were special and meaningful experiences for him.

I'd like to borrow this theme and ramble through my memory bank, sharing some of my personal recollections of this year with you, and emphasize why working for our Society is worth our individual and collective efforts.

I've been privileged to serve as the first woman president of one of the largest state medical societies in the country. Many people have asked me what this year has been like. I can sum it up in one word - exciting! However, behind that one word are others: stimulating, challenging, fun, occasionally exhausting and even unnerving at times. But never, ever dull.

Last year when I took office I chose the theme of looking forward to the future, but now I want to recap the past. As most of you are aware, the principal activity of your president is the "President's Tour," consisting of many visits to various county medical society meetings around the state. At these gatherings I was able to talk with many members and often their spouses. Some were small, intimate meetings, and others were gatherings of more than 100. These occasions allowed me to bring you up-to-date on Society matters and gave you the chance to voice concerns and ask questions about significant or troubling issues.

I have spoken frequently on your behalf to the media and the public on a variety of issues, the most notable being the Managed Care Patient Rights Act and its underlying principles. But I also had other issues to brag about. We achieved a variety of accomplishments including passing legislation to stop drive-through deliveries

and to increase women's access to obstetricians or gynecologists as their principal health care providers. But there were also our fights against drunken driving, smoking in health care facilities, partial-birth abortion and a misleading and wasteful doctor profiling system that would include malpractice data and would be available to the public.

The mementos you gave me reflect your thoughtfulness and friendship. They mean so much and will grow more precious as time goes on. All in all, this year was an unparalleled opportunity to grow, learn and experience new opportunities.

There are many people whom I have to thank for this past year. Starting on the home front, I want to thank Ron, my husband, and all the rest of my family for supporting me and not complaining about late dinners or no dinner and the household blizzard of paper and clutter. Wanda, my secretary, deserves special mention for holding the fort on the days I was gone.

I want to make a special reference to our ISMS staff. There are so many people with whom I have worked almost daily and who have truly smoothed the sails. The PR staff worked constantly with our media contacts, who are often challenging but so important. The field services staff kept the schedule on course and got me there in one piece and on time. The Illinois Medicine staff made sure the i's were dotted and the t's were crossed in these letters. The meeting and travel staff made countless reservations, often at the last minute. But frankly, it all boils down to you, the members. You set the course, provide the direction and trust your officers, Board of Trustees and staff to move us forward. I hope I've been successful in advancing our journey despite the occasional ill wind blown at us. After all, this truly was a team effort. I was privileged to be a part of it. I shall ever be grateful to you for these memories. Thank you.

GUEST EDITORIAL

Cutting costs

The following spoof on HMO-directed cost-cutting measures in hospitals was submitted anonymously:

Interoffice Memo

Date: 4/1/97
To: All hospital staff
From: Administration/groundskeeping
Re: New cost-cutting measures, as directed by our HMOs

Effective April 15, 1997, this medical center will no longer provide security. Each unit leader will be issued a .38 caliber revolver and 12 rounds of ammunition. An additional 12 rounds will be stored in the pharmacy. In addition to routine nursing duties, unit leaders will rotate the patrolling of medical center grounds. A bicycle and helmet will be provided for patrolling the parking garage. In light of the similarity of monitoring equipment, the CCU/sleep lab/epilepsy center will now take over the security surveillance duties. The unit clerk will be responsible for watching cardiac, brain wave and security monitors, as well as continuing previous duties.

Food service will be discontinued. Patients wishing to be fed will need to let their families know to bring something or make arrangements with Subway, Church's, etc., before meal time. Coin-operated phones will be available in patient rooms for this purpose as well as other calls the patients wish to make, thus enabling us to reduce the medical center telecommunications staff.

Occupational therapy patients, in the process of learning daily skills, will also perform the following tasks: bathe self and other patients, make all beds and clean rooms, process all accounts payable/receivable. The occupational therapist must be prepared to complete all tasks unfinished by a patient.

Housekeeping and physical therapy are being combined. Mops will be attached to all walkers so patients will exercise as well as clean the environment. As patients progress to independent ambulation they will be placed on a treadmill to turn the power wheel for the generators. Families may sign up to clean the rooms of nonambulatory patients for special discounts from their final bill. Time cards will be provided.

As you can see from the memo heading, administration is assuming groundskeeping duties. If an administrator cannot be reached by calling his/her office, it is suggested that you walk outside and listen for the sound of a lawnmower, weed wacker or leaf blower.

Cutbacks in phlebotomy and laboratory staff will be accommodated by performing blood tests on patients who are already bleeding.

The radiology staff is being reduced, and physicians will be informed that they may order no more than two X-rays per patient per stay. This is due to the turnaround time required by Walgreen's Photo Lab. Two prints will be provided for the price of one, and physicians are being advised to clip coupons from the Sunday paper if they want extra sets. Walgreen's will also honor competitors' coupons for one-hour processing in emergency situa-

tions. All staff are urged to clip these coupons and send them to the ER.

Audiologists will relocate to the telecommunications switchboard, testing the hearing of all callers using a system of repeating numbers.

The chaplain will conduct ongoing prayer services, thus eliminating the need for the recovery room.

In light of the cold this winter and in anticipation of another sweltering summer, ComEd has been asked to install individual meters in each patient room, office, etc., so that electricity consumption can be monitored and properly billed.

In addition to the paper recycling program, a bin for the collection of unused fruit and bread will soon be provided on each floor. Families, patients and the few remaining employees are encouraged to contribute discarded produce. The resulting moldy compost will be utilized by the pharmacy for nosocomial production of antibiotics. These antibiotics will also be available for purchase through the

hospital pharmacy and will, coincidentally, soon be the only available antibiotics listed on the HMO formulary.

A new parking structure will be built on the running track. All university students will be given the opportunity of staffing valet parking for the United Center on nights of Bulls home games. They can still do quarter-mile sprints between the garage and United Center, and the tips will defray tuition costs.

In these trying financial times, we know that our remaining staff will do their best to implement these minor changes while keeping morale at an all-time high.

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Committee seeks input on discovery process

PAGE 1

ISMIE Update

Contracts don't require a crystal ball, but it might help

Weigh every step carefully before joining a managed care plan.

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Through her employment, Ms. Smith joined an HMO that had contracted with independent participating physicians to treat its members. Each member of the HMO was required to select a primary care physician from a list of participating doctors, and that physician was responsible for coordinating the patient's treatment and referring the patient to specialists as necessary. Ms. Smith selected Dr. Nemo. Dr. Nemo received a capitation payment for each member who selected her, and she built up a very busy practice in this way. Dr. Nemo was happy that business was so good.

Shortly after selecting Dr. Nemo, Ms. Smith, who is a particularly unpleasant and abusive person, called Dr. Nemo's office complaining of vague epigastric pains. She gave a brief history to the office nurse in which she reported that the pains were just below her sternum and that they came on after spicy meals. (Later, in the litigation, Ms. Smith swore she told the nurse that she had shortness of

breath, diaphoresis and crushing pain in her chest with radiation into her left arm.) In a loud and offensive manner, she demanded to see Dr. Nemo right away. Dr. Nemo got the message from her nurse and decided that she could not possibly deal with Ms. Smith. Besides, Dr. Nemo had already assimilated 50 new patients into her practice that month, and there was simply no time to see this new patient right away. She had her nurse tell Ms. Smith to select another physician from the HMO panel.

Unbeknownst to Dr. Nemo, Ms. Smith was a 45-year-old obese woman who had a 10-year history of worsening hypertension (although she usually remembered to take her hypertensive medication) and who was a two-pack-a-day cigarette smoker. Shortly after calling Dr. Nemo's office and before selecting another physician, she suffered a severe myocardial infarction. She blamed it all on Dr. Nemo and named Dr. Nemo as a defendant in a lawsuit.

So, what of Dr. Nemo?

In our hypothetical case with Dr. Nemo, most courts would hold that the HMO contract, pursuant to which Ms. Smith

chose Dr. Nemo as her physician and Dr. Nemo received a capitation payment for managing Ms. Smith's care, provided sufficient groundwork to establish a physician-patient relationship between the two. This is so, even though Dr. Nemo had never seen or examined the patient and did not know her medical history. Dr. Nemo, therefore, was not free to decline treatment to the patient and, in our hypothetical example, she invited problems by turning away the patient's call for help.

Most of the difficult situations arising in today's managed care setting will not have legal definitions for some time. The circumstances surrounding care and treatment decisions will not preclude cases from being filed alleging all types of wrongdoing. When patient expectations are not met and when economic factors are perceived to be part of treatment decisions, physicians will be sued for malpractice. When entering into a relationship with new managed care patients, consider the following advice:

1. Be sensitive to the fact that the contractual arrangements you enter into in today's managed care environment have implications for your clinical



©Elle Schuster/The Image Bank

cal practice. These contracts do not require you to possess a crystal ball or know in advance the medical histories and problems of all your new patients, but they do create a legal and ethical duty running from you to the patient to use reasonable professional care. What that duty requires will vary with the circumstances.

2. Use "controlled lists." Either you or your office staff should review all patient lists from managed health care companies as they appear. Do not take on more patients than you can handle. It is unclear in some situations when the true physician-patient relationship begins, but we can assume that in capitated situations the relationship begins with the acceptance of the first monthly check. Are you willing and able to take on everybody on the list for 24-hour around-the-clock care? If you cannot and you have not already accepted a capitated payment, you must notify the managed care organization that you must pare down the list.

3. Develop intake procedures to establish contact with new patients and attempt to maintain a continuity of their care. For example, a new-patient contact sheet can be used to obtain basic health history information including current medical problems and medica-

tions. New patients should be encouraged to sign a release of medical records form to be forwarded to the previous treating physician and to any health care facility if necessary.

4. If it should become necessary to terminate the physician-patient relationship, use extra care, since the terms of your managed care contracts — such as capitated fee arrangements and prescribed termination procedures — must be considered.

5. Recognize that in the managed care environment, sound risk management practices are more important than ever. With the time constraints imposed by a busy practice, communication skills must be developed to ensure patient confidence, and work habits must be honed to ensure that thorough, contemporaneous written notes are prepared for patient encounters. Remember that the physician's legal duty is to use "reasonable professional care under the circumstances." Your contemporaneous written records are the best evidence of what those circumstances are, and thus they provide the foundation for defining your legal and ethical duty.

The best advice at present is for physicians to take action that is in their patients' best interest regardless of the MCO's rules or economic consequences. ■

MALPRACTICE ROUNDUP

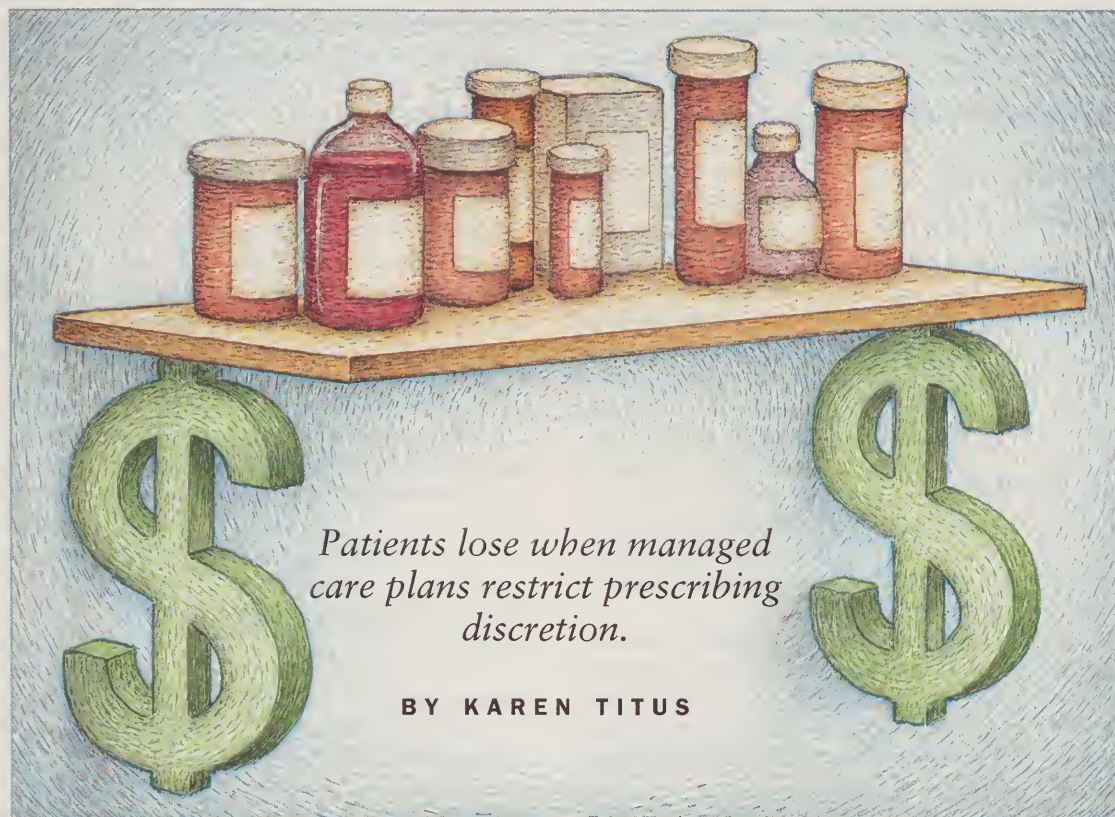
Plaintiff's expert didn't establish national standard

In *Travers vs. District of Columbia*, a plaintiff's expert witness attempted to establish a national standard of care about when aspirin should be administered to avoid blood clots in post-splenectomy patients. A District of Columbia appellate court ruled that the expert's discussions with other physicians were inadequate as a basis for establishing that standard, according to the January issue of *Medical Litigation Alert*.

After being injured in an auto accident, the patient underwent a splenectomy. Subsequently, he developed a blood clot above his ankle and gangrene, which led to partial amputation of his foot. The patient sued the hospital, and his attorneys contended that the physician's failure to provide aspirin in a timely manner caused the patient's platelet level to reach 800,000 to 1 million, constituting negligence.

The defendant moved for summary judgment on the grounds that the plaintiff failed to prove a national standard of care that surgeons in the District of Columbia would be required to follow. The motion was granted and affirmed on appeal.

Formularies built on dollar signs cause trouble



The scenario is chilling: A Chicago man suffers a stroke and ends up with an antihypertensive drug that wasn't prescribed by his physician. To save money, the patient's mail order pharmacy had switched him to another drug — one that had already proved ineffective in lowering his blood pressure. The problem came to light only when the man's son, a pharmacist, noticed it, reported the New York Times.

Such incidents have raised fears that as managed care plans rein in costs, physicians, patients and pharmacists may be shut out of the health care decision-making processes. After gag clauses, can restrictive formularies be far off?

According to some physicians and other health care professionals, they are already here. "I have encountered substitutions made by HMOs," said Arthur Traugott, MD, a psychiatrist at Carle Clinic in Champaign-Urbana and an ISMS Eighth District trustee. "The problem is, pharmacy costs continue to escalate as new drugs hit the market. So most managed care plans, understandably, are interested in controlling pharmacy costs. Until they learn the best way to do it, you see some pretty foolish stuff being done."

Sister Margaret Wright, president of the Illinois Pharmacists Association, said, "Physicians and pharmacists are losing control. The third parties are intervening, and they seem to be operating in a vacuum. They're working off formularies that are built on the dollar sign, irrespective of

the needs of the patient. That third party doesn't know this patient from a hole in the wall."

Such strong language isn't surprising, given the nature of the issue. What's at stake, physicians and pharmacists argue, is nothing less than their patients' well-being.

In dealing with restrictive formularies and possible substitutions, problems can occur on a number of levels, said William Kobler, MD, a family physician in Rockford and a 12th District trustee. The most critical one occurs when a plan wants to substitute a drug that has already proved ineffective for a patient, he said.

Another potentially troubling area involves generic substitutions for brand-name drugs. "Many drugs as generics are perfectly fine, but there are some you have to be careful of," Dr. Kobler said. "For some patients they just don't work as well."

Physicians may also find themselves overwhelmed

by the volume of managed care plans with which they interact, Dr. Kobler said. "If you're a physician who participates on the panels of a number of managed care organizations, you may be working with half a dozen different formularies. It gets to be a real practical problem within the physician's office." Sandwiched between making diagnoses and writing prescriptions is the need for physicians to identify which plan a patient belongs to, whether the plan has a formulary and what the formulary allows. Representa-

(Continued on page 8)

On your behalf

ISMS' House of Delegates periodically addresses pharmaceutical issues. Last year, the House agreed to oppose insurers' restrictions on "off-label" prescribing unless the carriers imposing restrictions could document problems with safety or effectiveness. The House also opposes directives to substitute cheaper medications without regard for side effects or compliance.

The ISMS Committee on Drugs and Therapeutics regularly reviews new drugs for the Illinois Department of Public Aid's formulary.

Formularies

(Continued from page 7)

tives for several Illinois managed care organizations were contacted for this story, but none returned telephone calls.

After some physicians began complaining about restrictive formularies a year and a half ago, the AMA began researching the issue, according to attorney Carol O'Brien, counsel in the AMA's Division of Patient Advocacy. In one case, an HMO formulary "contained a list of drugs that could fit on a standard business card," she noted.

Although O'Brien said such extreme complaints were rare, she added that the AMA is still investigating whether formularies are being used inappropriately. The association recently hired an attorney whose primary responsibility will be to determine the extent of the problem, and it will continue to monitor the situation through its Patient Advocacy Team, which O'Brien directs.

"The AMA isn't opposed to drug formularies," O'Brien said, "but it is opposed to clinically inappropriate drug formularies. If you're going to use a formulary, it has to be based on clinically appropriate standards and the physician has to have an appeals mechanism if he or she truly feels that no drug on the formulary is an acceptable equivalent for the prescription that patient needs."

What options do physicians have? Not many, said David Blumenfeld, a Chicago attorney who also holds a degree in pharmacology. "If a doctor for an HMO writes a scrip that is not in the formulary, it generally falls to the pharmacist [to make a decision]. What will

normally happen is the pharmacist merely tells the doctor that the drug is not listed, and the doctor will have to conform to the formulary.

"It's just like a hospital formulary," Blumenfeld continued. "In both cases, physicians can't write outside it unless they go through a prior approval process to obtain authorization."

Opinions vary as to the extent of managed care plans' flexibility in allowing physicians to write off the formulary. Stephen Hurwitz, MD, assistant professor of psychiatry at Loyola University

Medical Center in Maywood, reported little restriction by plans on the use of psychiatric drugs. "It's never a case of wanting to prescribe Prozac and not being able to because it's not on the formulary." What does exist, he said, is an incentive to prescribe generic medications over brand names because of the lower

copayments. "Cost is a consideration for many patients."

Robert Schnarr, immediate past president of the Illinois Pharmacists Association, expressed a harsher view: "There's no appeal mechanism anywhere. You have two choices: participate or get out of the program."

In Dr. Kobler's experience, however, managed care plans have generally been responsive to his requests to use medications that aren't on the formulary. "If you take the time to make the phone call and have a valid reason, it's usually not a problem." The same is true of writing prescriptions that aren't on the formulary of the Illinois Department of Public Aid, he said. "You have to get through the bureaucracy, but as with the MCOs, I've generally been pleased with my ability to get what I feel a

patient needs."

Dr. Traugott agreed, adding that it's important to be able to substantiate the reasons for prescribing outside the formulary. "We've had discussions with our [physician-owned] HMO, and we've worked out a system where prior approval can be given for certain medications. But I have to be able to provide valid medical reasons for a pharmacist and a medical director to review that and say, 'Yes, what Art Traugott is suggesting makes sense.' It can be handled reasonably if you have a reasonable plan."

Because titles and responsibilities vary from plan to plan, a customer service representative can usually help identify the person or division responsible for the decision to approve drugs not on its formulary.

Open communication between physicians and pharmacists is critical, Schnarr said. "I prefer to call physicians, rather than automatically making a change and assuming the physician knows it's occurred. I want his or her records to match my records."

While restrictive formularies draw much of the attention, pressure to use certain medications is not limited to

third-party payers. "With Americans' desire to have the newest and the latest, there's pressure on doctors and patients to use the latest pharmaceutical product that's out there," Dr. Traugott said. Patients may also be reluctant to try a different medication simply because they're uncomfortable with change, Sister Wright said.

Here again, communication with patients is important, physicians and pharmacists said. "When I prescribe medications, I expect that not only are patients on the medication I prescribed, but that they're taking it as prescribed. But that's not always the case," said Dr. Traugott. "Efficacy is more than just prescribing the drug you want and having it filled — you have to make sure there's a high level of compliance as well. This issue involves more than simply what's on a formulary."

Most agree that for improvements to occur, physicians, pharmacists and patients will all need to be involved. "It's the same as with gag clauses," Blumenfeld said. "Unless we keep our patients informed, and unless they demand more quality in their services, nothing will change." ■

If you're going to use a formulary, it has to be based on clinically appropriate standards, and the physician has to have an appeals mechanism.

Committee seeks

(Continued from page 1)

other things that are in their exclusive knowledge or possession and that are necessary to the parties seeking the discovery as a part of a cause or action that is pending or will be brought in court. Cini explained that the committee is not considering issues related to "substantive law" such as simplifying the process of filing suit against tobacco manufacturers. "[Discovery] involves depositions, requests for production of documents, notices to appear in court and payment of fee."

Steven Bordner, committee member and Illinois circuit court judge, said changes in discovery rules would apply to all civil cases. "This is going to affect

the small-town doctor who is required to testify as to someone's injury [from] a minor automobile accident, and it would apply equally to a neurosurgeon testifying in a medical malpractice case."

Bordner said the committee is specifically concerned about physicians who disrupt their practices when they clear their calendars for depositions. "[They] may get a telephone call the day before that says that the deposition has been canceled or continued to a new date. There may be good reasons why it was canceled or continued, but it is a source of frustration."

The committee may consider developing rules to minimize such disruptions, Bordner said, by "compensating the doctor in some way that would be fair to all doctors across the state or finding some other way to regulate situations in which they have been subjected to some substantial inconvenience."

One of four committee advisers, Eugene Pavalon, explained why the committee wants physician input: "Perhaps [physicians] are burdened to a greater degree with subpoenas and requests to testify in litigation than [people in] other professions." The committee also should consider physicians' different needs based on their specialties and whether their practice is in a rural or urban area, according to Pavalon, who is also an attorney in Chicago-based Pavalon & Gifford. Obstetricians, for example, may interact more often with the legal system than do physicians in other specialties.

The committee has no deadline for crafting its recommendations, but would welcome "input from the medical profession at their earliest opportunity," Cini said. Alfred Clementi, MD, a member of the Illinois State Medical Insurance Services Board of Directors, and ISMS General Counsel Saul Morse will work with the committee, according to Morse. In addition, physicians are encouraged to submit their opinions and experiences to ISMS General Counsel, 600 S. Second St., Suite 200, Springfield, IL 62704. ■



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Managed care bills

(Continued from page 1)

mittee by a 28-0 vote on March 21. The bill has attracted bipartisan support in both chambers with more than 45 sponsors in the House and 10 sponsors in the Senate.

Another comprehensive bill awaiting House consideration, H.B. 626, is sponsored by Rep. Mary Flowers (D-Chicago), chairman of the House Health Care Access and Availability Committee. "What we did was go to New York and bring back their version of the managed care bill. We wanted it to be a consumers' bill, not a bill favoring one group over another."

H.B. 626 includes elements of other bills, including MCPRA and a measure developed by the Illinois Association of Health Maintenance Organizations. Flowers' bill requires managed care plans to inform enrollees about plan procedures and benefits covered, and to establish grievance procedures and an independent external review. It also allows for public hearings for termination of physician contracts.

Flowers said she is optimistic about the chances of passage for H.B. 626. "There are a few i's that need to be dotted and t's that need to be crossed," she said. "A little bit more negotiation needs to be done."

A THIRD MANAGED CARE BILL, H.B. 1042, was developed by IAHMO with the backing of some business groups. The bill mostly outlines what is already current law and practice, and would not apply to all managed care plans in the state, according to a letter submitted to the Chicago Tribune by ISMS President Sandra Olson, MD. It "barely embraces the status quo," she wrote.

Jeff Mays, vice president of the Illinois Chamber of Commerce, which backs the IAHMO bill, said that as issues like gag rules and access to emergency care have surfaced, "the market has responded quite quickly to many of the concerns."

But Krause characterized the IAHMO bill as "legislation filed merely because they finally had to do something. It is an extremely weak bill, and I don't think it does anything."

An AMA attorney also labeled the bill as ineffectual because of its treatment of gag rules. Unlike MCPRA, the IAHMO measure prevents only some gag rules, according to Carol O'Brien, counsel in the AMA's Division for Patient Advocacy. For example, the IAHMO bill wouldn't allow a physician to talk to a patient about arrangements for continuity of care if the physician's contract was terminated.

Krause added that the piecemeal approach to managed care reform may have started because the "HMOs had not stepped forward at all with addressing the obvious concerns that the citizens have."

Some of the managed care bills that have been introduced are more narrowly focused, dealing with, for instance, MediPlan Plus, the state-proposed program to move more Medicaid enrollees into managed care. The U.S. Health Care Financing Administration is currently reviewing documents related to implementation.

Other narrower bills deal with such issues as direct access to specialist care

and coverage for specialized treatment. H.B. 188, sponsored by Rep. Larry McKeon (D-Chicago), would require insurers to allow enrollees direct access to endocrinology care providers. Insurers would have to cover nonprescription formulas and foods to treat or manage certain gastrointestinal conditions, according to H.B. 143, sponsored by Rep. Steve Davis (D-Wood River) and others. H.B. 843 states that dermatological services could not be denied because providers failed to refer patients for the services. Sponsors are Reps. Dan Rutherford (R-Pontiac) and Kurt Granberg (D-Carlyle).

Still other measures focus on insurance coverage of screening and education. H.B. 1330, sponsored by Rep. Ronald Wait (R-Belvidere), calls for insurers to cover mammograms, and H.B. 1909, sponsored by Rep. Lou Jones (D-Chicago) and others, would require coverage of prostate cancer screening. Insurance coverage of diabetes self-management training and education would be mandated by H.B. 1142, whose sponsors include Rep. Edgar Lopez (D-Chicago). In the Senate, S.B. 438, with sponsors including Sen. Kathleen Parker (R-Northfield), would require coverage for care related to

investigational cancer treatments.

Communication and denial of benefits are addressed in two bills. H.B. 535, whose lead sponsor is Rep. Ricca Slone (D-Peoria), calls for notices of denials of benefits to be signed by the individual responsible for the decision and to include the person's address and telephone number. The notice would have to include appeals information. And H.B. 333 would prohibit plans from interfering in certain communications between patients and providers. Sponsors are Reps. Sara Feigenholtz (D-Chicago), Judy Erwin (D-Chicago) and Lauren Beth Gash (D-Deerfield). ■

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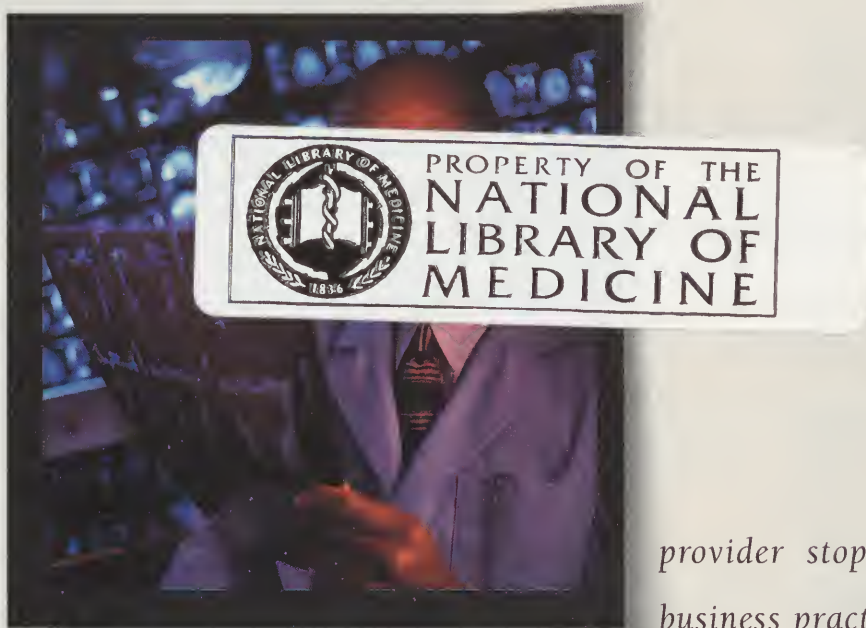
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PAGE 8

Illinois Medicine

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**Orchestrating
medications in
complex cases**

PAGE 7

Illinois House defeats physician profiling bill

LEGISLATIVE ADVOCACY: ISMS fought measure with member call to action.

BY JANE ZENTMYER

[SPRINGFIELD] On April 23, the Illinois House of Representatives voted 85-25 to defeat a bill that would have publicized personal and professional information about physicians' medical practices via a toll-free telephone number. ISMS opposed the bill because the profiles would have been "unnecessary, expensive and redundant," said ISMS immediate past President Sandra Olson, MD. The Society encouraged delegates to send a fax to their legislators during the recent House of Delegates Annual Meeting and released a call to action on

April 21 to urge members to contact their representatives.

Under H.B. 73, sponsored by Rep. Jan Schakowsky (D-Evanston), the Illinois Department of Professional Regulation would have been required to provide access to physicians' malpractice and disciplinary histories without appropriate interpretation of the information or confidentiality protections. Illinois Medicine tried to contact Schakowsky about her bill, but she did not return phone calls.

"Appropriate information about physicians is already

available to the public through a number of sources," Dr. Olson said. Illinois has a strong mandatory reporting law in place, which ISMS strongly supported, she added. "Under this law, IDPR receives reports on malpractice judgments against a doctor or settlements made on a doctor's behalf, criminal conduct, curtailment of a doctor's hospital privileges and peer review actions taken against a doctor by professional organizations. This information, when used properly by the Illinois Medical Disciplinary Board,

(Continued on page 14)



John McNulty

SYMBOLIZING HER INSTALLATION as ISMS president, Jane Jackman, MD (left), gets the president's medallion from immediate past President Sandra Olson, MD. The event took place April 20 at the House of Delegates Annual Meeting.

State Supreme Court accepts plaintiffs' amicus briefs in tort reform challenge

LEGAL CHALLENGE: Oral arguments are scheduled for May 21. BY JANE ZENTMYER

[SPRINGFIELD] On April 24 the Illinois Supreme Court announced its decision to permit three amicus briefs that will present plaintiffs' opposition to the tort reform law of 1995. Several organizations that support the law – including ISMS, the Illinois Civil Justice League, the Illinois Manufacturers' Association and the Illinois Hospital

and HealthSystems Association – have petitioned the court for amicus status but have been denied without explanation. The Court also selected May 21 as the date for oral arguments in Best vs. Taylor Machine Works, the case the Supreme Court will use to address the entire tort reform law.

(Continued on page 13)

Appellate court supports ban on corporate practice of medicine

DECISION: Rockford Memorial Hospital plans to appeal Holden verdict. BY JANE ZENTMYER

[ELGIN] On March 27 the Second District Appellate Court ruled in support of the ban on the corporate practice of medicine in Holden vs. Rockford Memorial Hospital. The ban is outlined in the Medical Practice Act of 1923 and

permits only licensed individuals to practice medicine.

"It is not this court's place to implement new law or institute new policy regarding the corporate practice of medicine doctrine," wrote appellate Judge (Continued on page 15)

Reps act on managed care reform

The Illinois House passed H.B. 626 on April 25 by a vote of 73-37. The comprehensive bill is sponsored by Rep. Mary Flowers (D-Chicago), chairman of the House Health Care Access and Availability Committee. The measure is supported by ISMS and contains elements of H.B. 603, the ISMS-developed Managed Care Patient Rights Act, which guarantees patients the rights to high quality of care, choice, individual respect, advocacy and information. A third bill, H.B. 1042, developed by the Illinois Association of Health Maintenance Organizations, failed to advance.

"H.B. 1042 purported to reform some of the managed care practices that have caused problems for Illinois patients, but it was truly only a thinly veiled attempt to maintain the status quo," said ISMS President Jane Jackman, MD. "Its title, the Managed Care Responsibility to Members Act, was a misnomer because it didn't demonstrate responsibility to patients in managed care

plans. ISMS urged lawmakers to oppose H.B. 1042 and support only legislation that offers long-overdue protections to patients and that makes managed care responsible to its enrollees."

Specifically, the bill's failings included the following:

- No point-of-service option allowing patients to go outside plans
- No prohibition on all forms of gag clauses and gag practices
- Limited choice of physician and defined access to specialty care
- No due process for health professionals dismissed from plans for reasons including patient advocacy
- No mechanism allowing physicians and patients to give input into the delivery of health care services
- Limited emergency service coverage
- Lengthy, three-day response time for review of denial of claims

Watch the next issue of Illinois Medicine for in-depth coverage of H.B. 626.

INSIDE

Doctors talk women's health



PAGE 3

State deals with insuring high-risk patients

PAGE 2

Tattoo removal helps patients break with past

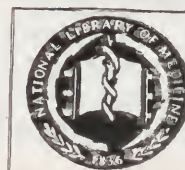


PAGE 5

DEPARTMENTS

Malpractice
Roundup.....7

Classifieds11



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Andrew Corrigan Halpern



AT AN APRIL 10 news conference in Chicago, Cook County Department of Public Health Director Karen Scott, MD, answers questions about the recent discovery of deer ticks in the county. Public health officials said they have no reports of Lyme disease cases contracted from tick bites in Cook County.

State may soon conform to federal law for insuring high-risk patients

CHANGES: Bill would require insurance assessments to cover some Illinoisans. BY CHRIS PETRAKOS

[SPRINGFIELD] Illinois may be one step closer to conforming to federal standards requiring insurance companies to provide coverage for high-risk individuals. On March 13, the Illinois Senate passed S.B. 802, the Illinois Health Insurance Portability and Accountability Act, and as Illinois Medicine went to press, it was being considered by the House. The bill would amend Illinois' Comprehensive Health Insurance Plan and insurance code. Meanwhile, the federal law goes into effect July 1, but states have until Jan. 1, 1998, to implement it, according to Rick Carlson, executive director of CHIP.

That federal law is the Kassebaum-Kennedy legislation, or the Health Insurance Portability and Accountability Act. Media coverage of the law has focused primarily on people who change jobs and whose employers provide health benefits. But the law also requires states to make sure that health insurance, without pre-

existing condition limits, remains available for people who leave the job market or move to jobs without health benefits. Under the act, insurers are prohibited from imposing a waiting period of more than 12 months for pre-existing conditions. To qualify, individuals must have had 18 months of continuous coverage, with no one break being 63 or more days. If the criteria are met, the federal law requires insurance companies to issue individual policies regardless of the person's pre-existing conditions. An "acceptable alternative mechanism" provision allows governors to seek an exemption for that requirement if they have programs in place to implement the federal law's individual health care reforms.

Established in 1989, CHIP issues health insurance policies to Illinois residents who, because of pre-existing medical conditions, are uninsurable or face very high insurance rates. CHIP enrollment was initially limited to 4,000, but

the demand for coverage led the the CHIP board to increase the enrollment cap to 5,200.

Carlson pointed out that Illinois was the first state to directly allocate state money to subsidize the operation of its health risk sharing pool. The average CHIP premium is about \$330 per month and is required by statute to be 135 percent of what private insurance coverage would cost. With such a high-risk pool, the state has experienced deficits, which are reimbursed by annual general revenue fund appropriations. Most states assess private insurance companies for the amount of the annual deficits, allowing them to deduct the assessments from their state tax bills. Under S.B. 802, CHIP will assess insurers to pay the costs of individuals eligible for CHIP under the federal provision.

ISMS Third District Trustee Janis Orłowski, MD, who is the Society's representative on the CHIP governing board, said the board "didn't want to be asking for a larger pool of money from the General Assembly. It is a federal mandate for the insurance companies to have this as part of their insurance pool, and if the state helps them by administering it, then insurers should pay for that."

State now offers three more protease inhibitors

[SPRINGFIELD] As of April 1, the state's AIDS Drug Assistance Program added three more protease inhibitor drugs to its formulary for HIV or AIDS patients who qualify for help.

The state began offering saquinavir mesylate to program recipients in January 1996, adding indinavir, zalcitabine and didanosine this spring. The U.S. Food and Drug Administration approved the latter drug in March. The program will also expand the total number of available drugs to 61 from 28.

"The use of a protease inhibitor, in combination with other drugs, has been found to be highly effective in suppressing the production of HIV, said Illinois

Department of Public Health Director John Lumpkin, MD. "This so-called 'cocktail' therapy offers hope to those living with HIV and holds the promise of HIV/AIDS becoming a manageable chronic disease."

Skyrocketing costs threatened ADAP's solvency when the first protease inhibitor drug became available last year. An infusion of state funds through a \$5 million supplemental appropriation in February, and the proposed 1998 budget will enable the program to remain viable and even expand to offer the new drugs, according to IDPH. The 1998 proposed budget requests \$15.8 million for the program, three times the amount

the state spent on ADAP three years ago.

The ISMS Council on Medical Service supported an increase in ADAP funding, and the Society's Board of Trustees adopted the council's recommendation on Feb. 1.

Beginning in June, IDPH also will place a \$1,000 per month drug benefit cap on ADAP's recipients to help control the program's costs, and the department will work to purchase drugs at the lowest wholesale cost available.

ADAP participants must be diagnosed with HIV or AIDS, have an annual income of no more than twice the federal poverty level, be ineligible for 80 percent or greater insurance coverage for drugs through another third-party payer, and be ineligible for payment of prescription drugs from another governmental entity. ■

ONE OF THE MOST significant reasons for using CHIP to administer HIPAA is that the federal law doesn't limit the amount that insurance companies can charge for an individual policy. Carlson said the current conversion policies available from private insurance companies either have very limited benefits – much less than what is typically available in group coverage – or if they are comparable to private insurance offerings, the policies can cost between \$700 and \$1,000 per month. By using an assessment against the insurance industry rather than forcing private insurers to cover all federally eligible individuals, the state hopes to avoid skyrocketing costs for individual policies. "There are states like New Jersey where the cost of an average individual policy is in the \$400 per month range," Carlson said. "The concern here is how to protect the current individual insurance market."

In addition to calling for the assessment, S.B. 802 would amend CHIP to bring it in line with other federal HIPAA requirements. Other changes at the state level would include increasing lifetime maximum benefits from \$500,000 to \$1 million, allowing CHIP rates to be between 125 percent and 150 percent of standard rates, and eliminating enrollment limits for federally eligible individuals. ■



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Percent of U.S. households with at least one adult on a caffeine-free diet

Age	
18 to 34	16.5%
35 to 44	16.7
45 to 54	20.7
55 and older	24.1

Source: Decision Analysis Inc., 1996

Doctors discuss women's health

CONFERENCE: Physicians talk to women in government about managed care, heart disease. BY JANE ZENTMYER

[SPRINGFIELD] The most important health care issue today is the conflict between patients' rights and insurers' interests, according to ISMS immediate past President Sandra Olson, MD, who spoke at a conference for women in government in Springfield April 10-11. Dr. Olson said that judging from such abuses as drive-through mastectomies and deliveries, that balance hasn't been achieved yet.

"Legislators have heard a lot of these stories, and at this point the debate seems to have moved past the point of whether we need a legislative solution to what kind of a bill we need to ensure the bond between patients, providers and payers, and preserve the integrity of the patient-doctor relationship," Dr. Olson explained.

The conference, co-sponsored by ISMS, offered educational sessions about women's health and other issues. The primary sponsor of the annual event is Illinois Women in Government, a group that educates women about governmental issues.

Dr. Olson explained that ISMS supports "a comprehensive answer to the key question that faces patients and their doctors today: In an era of managed care, what rights do patients have? As details continue to emerge and be refined through the long legislative process, we can find a simple answer to that question."

Before joining a managed care plan, patients should ask several key questions, advised Carolyn R. Bengtson, MD, vice president of medical affairs for managed care for the Rockford Health System. Those questions include, Is your doctor in the plan? Does your doctor refer to a hospital that you are comfortable with if hospitalization is necessary?

"Unfortunately many people buy their health insurance based purely on cost, and HMO coverage usually is the least expensive because it is the most managed," Dr. Bengtson said. "That doesn't make it the best for you unless you have already defined what your needs are."

In addition to managed care, one of the other health issues addressed was cardiovascular disease in women. ISMS President Jane Jackman, MD, said, "It's very much underdiagnosed both by women and their doctors. In fact, there are studies that show that women who present in the doctor's office with chest pains on average get fewer cardiovascular tests done than men with the same symptoms do."

Dr. Jackman described a patient who woke up one morning thinking she had

indigestion. She took Tylenol but didn't want to wake her husband or embarrass herself by calling her physician about a minor ailment. At 10 a.m., when Dr. Jackman's clinic opened, the patient finally called and was told to go to the hospital emergency department, where she learned she had had a heart attack. "She was one of the lucky ones," Dr. Jackman said. ■



DR. JACKMAN (left) and Springfield pediatrician Georgia Davis, MD, applaud a conference speaker. Other participating physicians included Jane Arbuthnot, MD; Caroline Halperin, DO; and Lisa Wichterman, MD.

Terry Farmer



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REPORT for Illinois Physicians

BCBSI PEPTIC ULCER DISEASE GUIDELINES

The American College of Gastroenterology Practice Parameters Committee guidelines are recommended for care for patients with dyspepsia and peptic ulcer disease. Key points of these guidelines are summarized as follows:

1. In patients with **known peptic ulcer disease** without NSAID use, there is a high probability that *H. pylori* will be present. Management alternatives include:

A diagnostic test for *H. pylori* with treatment if positive, and either empiric antibiotic use or further diagnostic testing if negative.

Empiric antibiotic therapy when ulcers are documented in the absence of NSAID use, because of the high prevalence of *H. pylori* infection and the poor predictive value of negative test results.

2. In patients presenting with **dyspepsia** who are not taking NSAIDs, there are several options for evaluation and treatment:

If alarm markers are present (anemia, GI bleeding, anorexia, early satiety, weight loss) immediate evaluation is indicated. This is also appropriate for new onset symptoms after age 50.

In the absence of alarm markers, there are three management options:

- a single, short-term trial (six weeks maximum) of empiric antiulcer treatment with workup for persistent symptoms after two weeks of medication or if symptoms recur after stopping empiric therapy;
- definitive diagnostic evaluation; and
- non-invasive testing for *H. pylori*, followed by antibiotic treatment if positive.

The following recommendations, while not specifically derived from the ACG Guidelines, are consistent with them:

1. Treatment for *H. pylori* should be with a combination of drugs that offers at least 85% likelihood of a cure.
2. Patients who have a history of peptic ulcer disease which has required maintenance medication and patients who have a history of peptic ulcer disease with complications should be evaluated for *H. pylori*.

Reference: (Soll, Andrew, Medical Treatment of Peptic Ulcer Disease: Practice Guidelines. JAMA. 1996; 275: 622-628.)

Issue: 050997 - AMK

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EDITORIAL

Bills that didn't get away

Bills that we support, like 1995 tort reform, get a lot of our attention. But defeating flawed bills in the General Assembly is every bit as important as passing well-crafted ones. In late April, the House dealt with two glaringly flawed bills that ISMS actively opposed. Representatives defeated one outright and returned the other to the House Rules Committee after failing to call it for a vote.

H.B. 73 would have created a toll-free phone number to publicize personal and professional information about physicians' practices. That would have meant that anyone – from plaintiff lawyers to the self-styled consumer advocacy groups they help fund – could have accessed malpractice and disciplinary history, plus other personal data. What they wouldn't have had access to was appropriate interpretation of that information, since malpractice suits often indicate high-risk specialties more than competence or quality.

The bill called for the Illinois Department of Professional Regulation to oversee the system. The cost was originally estimated at a whopping \$8 million, which would have covered reimbursement to physicians for reviewing their own profiles. That reimbursement was removed from the bill, which still left \$261,000 in start-up costs, \$225,000 in annual operation costs and the need for more IDPR staff. Money to run the program would have come from a fund financed through physicians' licensure fees.

IDPR currently gets reports on malpractice judgments, criminal conduct, curtailment of doctors' privileges and peer review actions, and uses that information to take action against physicians' licenses when appropriate. In addition, Illinois already has a strict licensure law and safeguards provided by peer review committees and credentialing by health care organizations. For all these reasons, ISMS issued a call to action on April 21. You responded, helping to defeat this potentially disastrous bill.

H.B. 1042, developed by the Illinois Association of HMOs, was misleadingly called the Managed Care Responsibility to Members Act. Unlike other true reform proposals – including ISMS' Managed Care Patient Rights Act and H.B. 626, which contains many core principles of MCPRA – H.B. 1042 didn't truly protect patients because of the following omissions: no prohibition of gag practices, no choice of physician or access to specialty care, no coverage of emergency services to protect patients, no point-of-service plan, no due process for health professionals dismissed from plans because of patient advocacy or other reasons, and no concern for patient risk, as shown by the three days allowed for review of claims denials. The measure ended up in the Rules Committee, but H.B. 626 passed.

Strong bills deserve our support; flawed bills like H.B. 73 and H.B. 1042 warrant our opposition and the end they ultimately met: failure.

PRESIDENT'S LETTER

The best interest of the patient is the only interest

Jane L. Jackman, MD



"The best interest of the patient is the only interest to be considered, and in order that the sick may have the benefit of advancing knowledge, the union of forces is necessary."

— William J. Mayo, MD

This quotation by one of the founders of the largest group practice in the United States of America, to me, encapsulates not only what it means to be a physician but also how to preserve our professionalism and ethics. These words of advice are as relevant today to the doctors of Illinois as they were to that small group of doctors from southern Minnesota at the turn of the century.

Many times it is difficult for us to remember why we chose medicine as a career. Increasingly intrusive laws, ever more-brazen regulators, business interests' movement into medicine and interference with the doctor-patient relationship – these and more are part of the growing hassle factors we live with in medicine. Assaults on our ethics by managed care gag clauses and gag practices, drive-through deliveries, drive-through mastectomies and, no doubt, drive-through body parts of the week make us wonder if we wouldn't be better off in another profession.

From time to time, all of us would be helped by doing some serious reminiscing about what motivated us to choose this noble profession in the first place. We would find that our reasons were not simply because of the intellectual challenges and excitement that medicine gives us. I also doubt the reason was money, since that is getting less all the time and since there are much easier ways to make a living! Most of us wouldn't even have chosen medicine for the social prestige that MD still gives to its owner but that is starting

to tarnish a little around the edges as medicine becomes more high-tech and less high-touch. If we all really did some serious soul-searching, we would find that the real reason we chose medicine was because first and foremost we all wanted to care for and protect other human beings through the art of healing the sick. We all do, therefore, have a common purpose and mission through our work.

Our Illinois State Medical Society was founded 157 years ago for the purpose of standardizing medical practice, improving medical education and developing a common code of ethics and professionalism for our members. Of necessity, with changes in social values, technology and medical knowledge, our code of ethics has had to change over time. However, our code of professionalism has not changed one iota in the last 157 years.

To be a professional in 1997 means exactly the same thing as it did in 1840. And that code of professionalism says that the doctor must always put the interests of the patient above the physician's own interest. When they seek our care, our patients are vulnerable. They want a good one-on-one relationship with a doctor who's empowered to do what's right for them. They support our clinical autonomy. In fact, they are counting on us to look out for their best interests. For us to be effective in this, the "union of forces" is absolutely essential.

Our Illinois State Medical Society is the obvious rallying place for us to come together, to unite as the family of medicine, to speak with one voice to both the Legislature and the public. If we can settle our differences amongst ourselves, if we remember our common roots and our common codes of ethics and professionalism, and if we are willing to be energized, active and involved in ISMS, we will be a formidable force! Our patients are counting on us. Let's not let them down.

GUEST EDITORIAL

Tattoo removal symbolizes break from past

By Andrew Kramer, MD

I'm one of three physicians who remove gang-related tattoos from former gang-bangers through Fresh Start, a free program sponsored by St. Joseph Hospital in Elgin. I initially got involved because of my interest in laser surgery, but the demands for our services – and our patients themselves –

have compelled me to stay involved.

When Fresh Start began three years ago, we expected to have about 200 participants per year. But within 24 hours of the announcement, more than 1,700 people had requested the services. Most of our patients come from Chicago, and as other hospitals begin offering similar

services, we'll be able to focus more on Kane County.

Most of the tattoos we remove are homemade, involve symbols and are a dark color. Usually someone in a gang knows how to tattoo other members, and the "artists" may tattoo letters across the knuckles or print the gang's emblem on members' forearms or elsewhere on their upper bodies.

Gang members all have tattoos to identify their affiliation and to show their commitment. That's why when they leave the gang, they have to get rid of the tattoos to show they've made a clean break. In fact, we remove tattoos for free only if they're gang symbols and the patients are willing to leave the gang. We don't have guarantees that the latter will occur, so the best we can do is trust them. Many of our patients have been ordered by judges to remove the tattoos and end their affiliation or they've been referred by employees of jails or sheriff's departments.

As I do the laser surgery procedure, I like to talk to the patients. A lot of them understand that to get out of the gang, they have to get out of the area. That works best. Many have been punished by the gang after they decided to leave. They may have been beaten up. So, they may feel their lives are still at risk, and the only real option is to disappear.

Our patients range in age from the early teens to their 50s. Some have small children who have given them a desire to change their lifestyle and live longer. If they're able to get out of the gang and feel good about that accomplishment

and their new lifestyle, they won't have to resort to their previous behaviors.

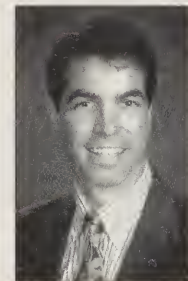
After members leave the gang, their self-esteem increases. They become success stories, and they know their life as gang-bangers was a mistake. One patient who went through Fresh Start helped organize a similar tattoo-removal service at a Chicago-area hospital. Not only did he leave his gang lifestyle, but he found a way to help other former gang members.

Not all our patients are as lucky, though. One committed suicide, and another was killed in a drive-by shooting.

Even the process of getting tattoos poses risks for the recipients regardless of whether the artists are amateurs or professionals. Tattoos are created through a much more invasive process than the work done by, say, cosmetologists, who are already licensed by the state. If certain standards of hygiene and sanitation aren't maintained during the process, infections and bloodborne diseases can be transmitted through the needles. That's why I believe that tattoo artists should be licensed. Although a bill that would have licensed tattoo artists stalled in the Illinois House this session,

physicians should keep working at and supporting the goal of licensure.

Dr. Kramer is a general surgeon based in Geneva and president of the Kane County Medical Society.



Roll call vote on H.B. 73 in the Illinois House of Representatives

NO

Edward Acevedo (D-Chicago)
Jay Ackerman (R-Morton)
Mark Beaubien Jr. (R-Wauconda)
Robert Bergman (R-Palatine)
Judy Biggert (R-Westmont)
Bob Biggins (R-Elmhurst)
William Black (R-Danville)
Mike Bost (R-Carbondale)
Phillip Bradley (D-Chicago)
Bill Brady (R-Bloomington)
Joel Brunsvold (D-Rock Island)
Robert Bugielski (D-Chicago)
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Tom Cross (R-Yorkville)
Julie Curry (D-Mount Zion)
Lee Daniels (R-Elmhurst)
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Steve Davis (D-Wood River)
Terry Deering (D-Nashville)
James Durkin (R-Westchester)
Arlene Fantin (D-Calumet City)
John Fritchey (D-Chicago)
Kurt Granberg (D-Carlyle)
Gary Hannig (D-Gillespie)
Chuck Hartke (D-Effingham)
Brent Hassert (R-Lemont)
Douglas Hoeft (R-Elgin)
Thomas Holbrook (D-Belleview)
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Tim Johnson (R-Urbana)
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Kay Wojcik (R-Schaumburg)
Corinne Wood (R-Lake Forest)
Larry Woolard (D-Marion)
Wyvetter Younge (D-East St. Louis)
Anne Zickus (R-Palos Hills)

YES

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Glenn Bradford (D-Edwardsville)
Jim Brosnahan (D-Oak Lawn)
Maggie Crotty (D-Oak Forest)
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Douglas Scott (D-Rockford)
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Todd Stroger (D-Chicago)

PRESENT

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Ricca Slone (D-Peoria)

ABSENT

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Judy Erwin (D-Chicago)
Sara Feigenholtz (D-Chicago)
Calvin Giles (D-Chicago)
Constance Howard (D-Chicago)
Jeffrey Schoenberg (D-Wilmette)

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*Because medicine
is no longer
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Campaign to help women put their health issues first

INITIATIVE: Toll-free phone number will help with changes, problems. BY DAVE WIETHOP

[OAK BROOK] For some Illinois women who face two of the big "M" words — "midlife" and "menopause" — answers to questions about the changes they're experiencing may be as close as their telephone. Illinois' first lady Brenda Edgar talked to physicians attending the April 19 Public Affairs Breakfast at ISMS' House of Delegates Annual Meeting and asked for their support for the Illinois Women's Health Campaign to be launched later this month.

"I'm no expert on women's health care, but I am a woman," Edgar said. Women experience many changes in their bodies as they grow older, she said, and although "change can be good, it can also be frightening and confusing."

The Women's Health Campaign will provide a toll-free telephone number, (888) 522-1282, which will become operational May 15 to offer women age 40 and older an array of information about their health issues. The first lady asked physicians to provide the toll-free number to their patients.

Besides providing a clearinghouse of information through the toll-free telephone line, the Women's Health Campaign will develop publications and pub-



John McNulty

Edgar chats with Nestor Ramirez, MD, chairman of ISMS' Governmental Affairs Council, at the IMPAC Public Affairs Breakfast on April 19.

lic awareness materials, conduct special events and promotions, and create public and private partnerships with companies, universities and women's organizations to build a coalition to advocate for women's health.

ISMS and 20 other organizations and state agencies are partners with the women's health initiative. The governor announced plans for the campaign during his Jan. 22 State of the State address,

First lady leads 'Mansion Meeting on Youth Violence'

Illinois' first lady Brenda Edgar, long an advocate for children's safety issues, convened the first-ever "Mansion Meeting on Youth Violence" on April 17 for more than 125 educators, students, violence prevention organizations, ministers, law enforcement officials and government officials.

Attendees of the meeting, which was co-chaired by Edgar and Athletes Against Drugs founder Stedman Graham, looked at the prevalence of youth violence in Illinois schools. Children and young people are twice as likely to be the victims of violence, and youth-perpetrated violence is rising continuously, according to the Illinois Criminal Justice Information Authority and the Illinois Council for the Prevention of Violence. In addition, the number of juveniles taken into police custody for serious offenses skyrocketed by 70 percent between 1983 and 1995, and the number taken into policy custody for murder quadrupled.

The report from the meeting will be forwarded to the Illinois Violence Prevention Authority, an organization that coordinates, funds and evaluates public health and safety approaches to violence prevention in the state. The authority was established by Illinois Attorney General Jim Ryan and Illinois Department of Public Health Director John Lumpkin, MD, who said the meeting on youth violence will be useful as the authority develops a three-year violence prevention plan.

— Dave Wiethop

saying that primary funding will come from the private sector.

In her address to delegates, the first lady cited surveys that show that U.S. women often place their own health as a top priority, but she said that in reality women's health generally takes a back seat to care for their families and friends.

Women at midlife are at increased risk for heart disease, breast cancer and other illnesses — issues that merit serious attention, Edgar said. The same women who urge their children to drink milk to build strong bones face the risk of osteoporosis.

And "women are more likely to be diagnosed with depression, and it is important to understand that this is not a choice nor is it a character flaw," she noted.

Women are at greater risk of developing a serious health problem than of being a victim of battery, car accidents, muggings or rapes, Edgar added.

The target audience of the Women's Health Campaign has simple expectations, Edgar said. "Their mission is to be normal, and they have the same questions as their mothers about such things as hormone replacement therapies." ■

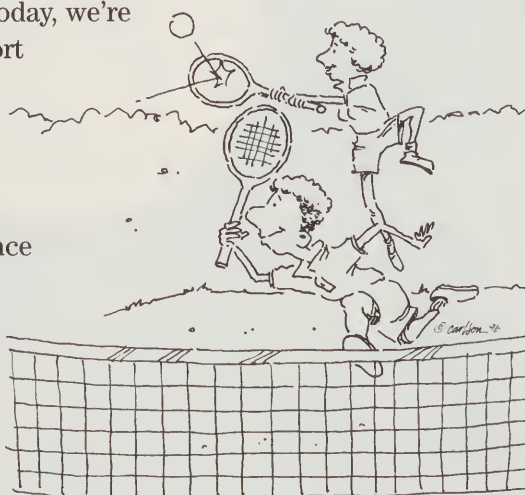
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Illinois House defeats physician profiling bill

PAGE 1

ISMIE Update

*State Supreme Court
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amicus briefs in tort
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PAGE 1

Orchestrating medications in complex cases

Problems can stem from a lack of coordination or information,
but communication is the key. BY CHRIS PETRAKOS

Treating patients who have a variety of ailments raises some complex clinical challenges. One such challenge is prescribing for and following up with patients who are taking numerous medications especially when several physicians are involved in their care.

Jim Neville, an attorney at Neville, Richards, DeFranco & Wuller in Belleville, has been involved in several cases where multiple physicians were sued by a patient. The problem may be not just between the physician and the patient, but between physicians as well. "It can get a little sticky because the primary doctor will defer to the specialists, all of whom are prescribing different medications." Conversely, some specialists feel more comfortable dealing with only their area, he said. "There is not a clear sense of who is captain of the ship."

If a lawsuit is filed, that lack of cohesiveness can create a problem in court, too, Neville said. "In the cases I've run into, you have the specialists saying that they were only tak-

ing care of their part of the patient. The problem for the defense is that you've got everybody pointing fingers at each other, which is only going to help the plaintiff."

"One physician has to take charge," said Joseph Prosser, MD, medical director of St. Elizabeth's Hospital in Belleville. "That physician has to know what everyone else is doing, be the communicator and look over everybody else's plan and make sure that there is no conflict. For example, if a cardiologist is trying to give a beta-blocker at the same time a pulmonologist is trying to treat wheezing, they may be at odds. In theory, every doctor should know what every other doctor is doing on the case, but in reality, that doesn't always happen. So there needs to be one person who is absolutely paying attention to everything."

In addition to a lack of orchestration, a lack of information can be a problem. Neville said the problems he has seen have come about largely through lack of communica-



©James Yang/SSI

tion. "And that's true whether the patient is hospitalized or is being seen on an outpatient basis." Neville cited a recent case involving a physician who was unaware that a psychiatrist was prescribing medications for a patient they were both treat-

ing. That's one reason that getting a thorough patient history is critical. "If the patient advises you that he or she is treating with another doctor, certainly an argument could be made that you should obtain the relevant records from the other doctor. It doesn't have to be all the records – the diagnosis and treatment including medications prescribed would be enough."

One way to avoid a problem is by establishing good communication with the patient right from the beginning, according to Andrea Baumgartner, MD, a Chicago cardiologist. "With a new patient, one of the first things you want to know is who the other treating doctors are. And if you are the primary care doctor, you want to impress upon the patient that you are in charge of their prescriptions. If another doctor puts them on something, you need to be alerted about it, especially if the patient is on a medicine with known drug interactions, like Coumadin." That notification should come as

soon as possible, she noted.

The extent of communication between physicians depends not only on the patient's condition, but also on the physician's relationship with the patient, Dr. Baumgartner said. "If I have a patient who is very reliable, I don't usually have to talk to his or her doctors. But there are lots of other times when I tell the patient that the other doctors have to call me. Sometimes the triggering mechanism is going to be the seriousness of the medications that they are on and the potential for adverse reaction. Another situation is with older patients who may forget all the medications they're taking."

Dr. Baumgartner said that over time, she has developed some ways of dealing with patients who are on complex regimens. One of the most helpful is asking patients to bring in their prescriptions periodically. "Lots of times, you write a prescription and assume that the patient is taking it as instructed, and it turns out that they're not."

It's a good idea to encourage patients to call and ask for clarification if they have any questions. "A lot of people do call me about things, and I'm glad because it means that they're looking at the label," Dr. Baumgartner said. ■

MALPRACTICE ROUNDUP

Specialist liable for failing to order teen-ager's CT scan

A Passaic, N.J., jury awarded \$1.5 million to a teen-ager who experienced recurring headaches and sinus infections for four years, developed an abscess and osteomyelitis, and underwent a craniotomy. She sued her pediatrician and otorhinolaryngologist for failure to order a CT scan, according to the January issue of Medical Litigation Alert.

In *Solowski vs. Holtzburg*, the teen-ager sought help from the ENT when antibiotics prescribed by her pediatrician failed to clear up her sinus infection. The otorhinolaryngologist testified that the patient complained only of nasal discharge, not headaches, which didn't merit a CT scan. The teen-ager's attorney argued that the scan could have helped diagnose the osteomyelitis that developed in the epidural space, compressing the frontal lobe. The ENT argued that even if the abscess had been present before the first patient visit, the craniotomy would have been required.

The patient claimed that the craniotomy scars on her forehead were permanent and disfiguring and they, along with her sensitivity to light and constant headaches, caused her to be reclusive and kept her from enjoying high school and her freshman year of college. The defense responded that the scars were mostly confined within the hairline and not visible.

The jury exonerated the pediatrician but found the ENT negligent. The gross award of \$1.5 million was reduced by 4 percent to reflect the existence of a pre-existing condition.

Jury awards \$18.4 million for delayed cesarean

A woman who had previously given birth by cesarean section sued her obstetrician for failure to perform a cesarean quickly enough in delivering her second baby, who was born with permanent brain damage, cerebral palsy and developmental delays. A Sacramento, Calif., jury awarded the mother and the baby \$18.4 million, reported the March 31 issue of the National Law Journal.

In *Correa vs. Methodist Hospital in Sacramento*, the patient was admitted to the hospital and given Pitocin to speed her labor. After 11 hours, hospital records showed that a cesarean was recommended but that the patient declined. The obstetrician testified that when he went home, the patient's labor was continuing and the fetal monitor showed no problems. The monitor strip eventually showed periodic variable decelerations, and when the fetal heart rate dropped below 100 for more than five minutes, the physician was called. The doctor prescribed medication, but the fetal heart rate continued falling, so the physician was called again. He rushed to the hospital and performed an immediate cesarean.

The physician and the hospital disagreed about whether the doctor had been properly informed of the drop in the fetal heart rate, but both parties claimed the injuries occurred before the heart rate dropped. The defendants also said that the damage to the baby occurred before the prolonged drop in fetal heart rate, so it would not have helped to perform the cesarean more quickly.

Post-trial motions are pending, according to the article.

New ISMS president will reach physicians where they live

A 30-year career in family practice and extensive volunteer work and involvement in organized medicine have helped prepare Downstate physician.

BY JANE ZENTMYER

At first, the patient, a woman in her 60s, thought her back pain was nothing – the effect of age or arthritis. But when she saw her family physician, Jane Jackman, MD, she learned the bad news: She had metastatic lung cancer. Toward the end of her battle with cancer, the patient organized her last Thanksgiving dinner from her hospital room before going home to die, Dr. Jackman recalled. “She said this was probably going to be the best Thanksgiving because she usually spent her time running around the kitchen and had no time to talk to anyone. For this one, she was planning on talking to everybody.”

From that patient, Dr. Jackman, who was inducted as president of ISMS last month, said she learned something about her role as a family physician: “We don’t always have all the answers, but quite often patients can inspire us to deal with difficult situations.”



Photos: Kevin O. Mooney

Dr. Jackman dealt with difficulty when she was a child in England watching her mother battle breast cancer. The physician who cared for her family inspired her, she said. “I became fascinated by the aura that surrounds the doctor when families are distressed like that. In those days, doctors still made house calls, and the family doctor came once a week. We hung on every word he said. I began to think, ‘Boy, there’s something special about this person.’”

Her interest eventually led her to the University of Birmingham Medical School in Birmingham, England. The medical school had an exchange program with the University of Minnesota, which Dr. Jackman participated in during her senior year. She then went home to England but returned to Minnesota for her internship at Paul Ramsey County Hospital. It was there that she met radiologist Steven Jackman, MD, who became her husband after she finished medical school.

Dr. Jackman didn’t begin her medical career with the intention of becoming a family physician. She began a radiology residency at the University of Maryland, but her husband enrolled in the Berry Plan – a lottery for physicians who wanted to complete their internships and residencies before entering military service – and was transferred to Houston, Texas. So, Dr. Jackman went to work for the U.S. Public Health Service Clinic as a general practitioner and decided to pursue family practice.

She said that for radiologists, “it’s very difficult to get satisfaction back from patients. You may make a brilliant diagnosis through reading their X-rays or doing diagnostic studies on them, but as far as actually following them from square one all the way through their illness and hopefully, recovery, you don’t get to do that.”

THE JACKMANS MOVED to Springfield in the 1970s and had four children: Kathy, who is now applying to medical school; Bill, who works at Hewitt & Associates in Chicago; Mary, a horticulture major at Montana State University; and Brian, a high school freshman. After taking a few years off to rear her family, Dr. Jackman started practicing at Capitol Healthcare, a group of physicians in private practice. Today, she’s also a clinical associate professor in the department of family practice at the Southern Illinois University Medical School.

Dr. Jackman said that because she has been inspired by many individuals, she believes all physicians should serve as role models in their communities to help inspire others. Her volunteer work is extensive. She helped start the HealthFirst Community Clinic, a Springfield clinic that provides free health

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care to those who lack access. And when Downstate communities flooded in 1993, she was one of the volunteers piling sandbags along the riverbank. "As a physician, you are expected to be a leader in your community, serving as an example to other people. In most doctors, there is a general spirit of wanting to give back." She added that being a role model to her children is even more important to her.

She wanted to give something back to the medical community, too. For instance, at the Sangamon County Medical Society in the early 1980s, she headed a committee researching how health maintenance organizations work – a job no one else wanted. Back

then, HMOs were foreign to most physicians, but her committee soon played an important role at the county medical society. Dr. Jackman's interest in organized medicine grew, and she eventually served as president of her county society.

Dr. Jackman will have the opportunity to tap her knowledge of HMOs during her ISMS presidency. This year, the Society developed

a comprehensive managed care reform bill, the Managed Care Patient Rights Act, to guarantee that patients have protection in five basic areas: quality, choice, individual respect, advocacy and information. The measure was introduced into the General Assembly, and lawmakers considered it along with numerous other reform bills. Dr. Jackman said that it's about time managed care became a hot topic.

"Managed care really has caused a big interference in the doctor-patient relationship, and patients are just now beginning to realize the problems that occur," she explained. "It may be cheaper for you to buy a man-

aged care plan, but when you actually get sick and need to use services, there are may be a lot of stumbling blocks in the way of getting good medical care."

Those stumbling blocks can lead to heart-breaking results. Dr. Jackman remembered an 18-year-old college-bound patient who finally summoned enough courage to talk about the bulimia she had fought since her early teens. Although Dr. Jackman knew where to refer the young woman to get help, the patient's managed care plan required patients – not their attending physicians – to discuss such problems with a plan representative before referrals could be made. It's unlikely the teen-ager ever made that call, Dr. Jackman said.

As managed care penetration and its impact have increased in Illinois, the collegiality between primary care physicians and specialists has declined, to the detriment of medicine, Dr. Jackman said. "One of my jobs is to coordinate the total care of patients and to direct them through a maze of specialist care. We live in a high-tech age, and I can't take care of all the needs of all my patients. In order to do my job well, I need good specialists, and I need their cooperation. For specialists to provide good specialty care, they need the cooperation of the primary care doctor."

Dr. Jackman said she wants to help dispel the divisiveness between primary care physicians and specialists during her term as ISMS president. She added that the Society represents both groups: "The truth is, ISMS' loyalties are in the middle – a balance between primary care physicians and specialists."

Dr. Jackman said she plans to expand her travel schedule to meet as many physicians possible, if only to better understand the business and practice of medicine throughout the state. "I think the only way to really find out what's going on is to seek doctors out in their own communities and see what's going on there, what their problems are, and talk to them face-to-face," she said. "The most important job I have this year is to get out and meet people and find out how ISMS is going to help them." ■

The only way to really find out what's going on is to seek doctors out in their own communities and see what's going on there.

National IPA coalition supports physician-directed managed care

LEADERSHIP: Group recommends learning by example.

BY JANE ZENTMYER

[OAKLAND, CALIF.] When Jeff Mason, MD, and his colleagues formed the IPA called Fante Community Physicians and began accepting risk in 1988, no one showed them how to do it. "We didn't know what we needed. We had to stumble around trying to figure it out,"

said Dr. Mason, vice president for medical affairs of the Fresno, Calif.-based group. "We didn't know what kind of business expertise to look for. We didn't know what kind of systems to look for. We didn't know what kind of policies and procedures to implement."

Almost 10 years later, Fante Community Physicians is responsible for 54,000 capitated lives and contracts with Medicare and commercial HMOs, and more than 600 physicians participate in the multispecialty group, Dr. Mason said. "For physicians who are thinking about forming organizations to accept risk, it is to your advantage to use the resources that are available. Any time you do assume risk you're exposing yourself to the potential of financial failure."

One of those resources to help physician organizations succeed is the National IPA Coalition (NIPAC) based in Oakland, Calif., which Dr. Mason's group joined.

The coalition began in 1993 as the IPA Coalition of California "essentially to meet the need for fairly young organizations to network and learn from each other's experiences and to provide some substantive education for them," said Nancy Oswald, NIPAC president. Earlier this year, the group changed its name to the National IPA Coalition and opened its doors to members across the country. Current membership totals 140 physician organizations in 10 states.

Physician organizations can take many forms, and each may develop its own level of sophistication, she said. "An IPA in California and an IPA in other parts of the country are very different things," Oswald explained. "How we define an IPA is an organization of physicians that has or intends to contract in the managed care market."

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It is that sort of organization that NIPAC aims to help: "Our intent is that the lessons that have been learned by physicians building their organizations here will help physician organizations elsewhere have a much shorter learning curve," Oswald said.

NIPAC focuses on three areas: tools for operational success; collaboration, representation and advocacy; and education, training and networking, according to Oswald. She explained that the group doesn't provide management services to physician organizations but is compiling a list of consultants to whom they can refer members who have questions about business practices.

Dr. Mason said his group uses NIPAC's IPA Clinical Operations Manual, which discusses how to set up utilization review programs and how to resolve grievances. In fact, his group provided input into the development of the manual.

NIPAC has helped create forums through which physician-led organizations can work with employers, health plans and the U.S. Health Care Financing Administration, Oswald said.

The association also holds conferences, leadership programs and workshops to get physician leaders together to learn from one another. Its first conference outside California will be held May 30-31 in Chicago at the Westin Hotel near O'Hare Airport. The conference - called "The Health Care Imperative: Enhancing Physician-Directed Managed Care" - will include sessions on organizing to manage risk, physician leadership, the role of physician organizations in the health care system, successful strategies for contracting with health plans and compensation models for physicians.

"In Illinois, I understand that maybe groups haven't advanced quite as far in terms of accepting risk or capitation," Dr. Mason said. "If groups are interested in taking that path - and there are a lot of advantages to physicians who do that - NIPAC has a lot to offer in terms of having been sort of a pathfinder organization."

For more information about the conference, physicians may call (800) 626-4722.

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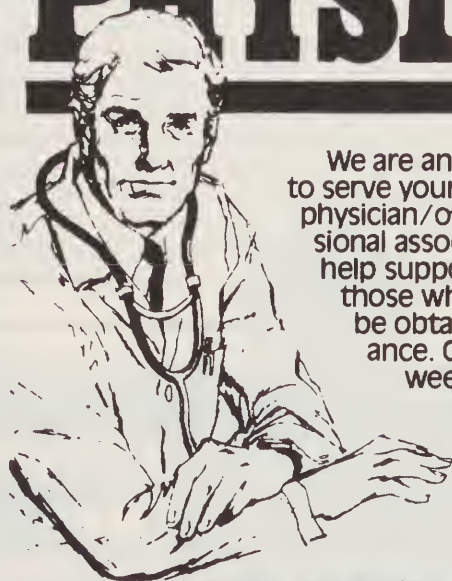
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State Supreme Court

(Continued from page 1)

Each of the accepted amicus petitions has two groups supporting it: the Brotherhood of Health and Frost Insulated Local 17 and the Southeast Environmental Task Force; the Southside Branch of the National Association for the Advancement of Colored People and the Cook County Bar Association; and the Illinois National Organization for Women Legal and Education Fund and the Breast Implant Information Exchange.

"We're very disappointed that the Court has decided to allow amici on only one side of the issue," said Ed Murnane, president of the Illinois Civil Justice League. "Fairness suggests that all sides be allowed to express their expert views on what is very complicated and important legislation."

The fact that Prof. Tribe is arguing this case shows the importance the plaintiffs' bar attaches to this matter.

"This raises questions about why the Court is hearing from only one side," said ISMS General Counsel Saul Morse. On the defense side, only Illinois Attorney General Jim Ryan will be allowed to file a brief in support of tort reform by using his office's constitutional right to be an "intervenor."

Best vs. Taylor Machine Works is a product liability case originating in Madison County. It stems from a forklift accident and does not involve physicians or the medical malpractice provisions of the tort reform law. Nevertheless, the trial court judge ruled the entire law unconstitutional. The entire case was then sent to the Supreme Court, which chose to hold all other pending tort reform cases in abeyance until the seven justices issue a ruling on Best.

On the same day the plaintiff attorneys filed briefs requesting amicus status, well-known Harvard Law School professor Lawrence Tribe also requested permission from the state high court to argue the case for the plaintiffs. His request was granted. "The fact that Prof. Tribe is coming in to argue this case clearly shows the level of importance the plaintiffs' bar and their supporters attach to this matter," Morse said.

In March, the Supreme Court heard oral arguments in Kunkel vs. Walton, a tort reform case omitted from the Supreme Court's earlier motion that stayed all pending tort reform cases except for Best. The Kunkel case challenges revisions to the Petrillo doctrine

that now require plaintiffs' attorneys to provide written consent authorizing the release of their clients' medical records within 28 days of requests or face case dismissal or a court order requiring the document release. The justices still have the option of combining their decisions on Best and Kunkel.

"Setting the [Best] case for argument May 21 leads me to the view that the Court wants to deal very quickly with this issue and that it may think it can issue an order yet this summer," Morse said. "It also leads me to the belief that the Court is likely to consolidate this case with Kunkel." ■

THE ENTERTAINMENT at "President's Night" drew the applause of ISMS immediate past President Sandra Olson, MD, and her husband, Judge Ron Olson. The event was held April 18 during ISMS' House of Delegates Annual Meeting.



John McNulty

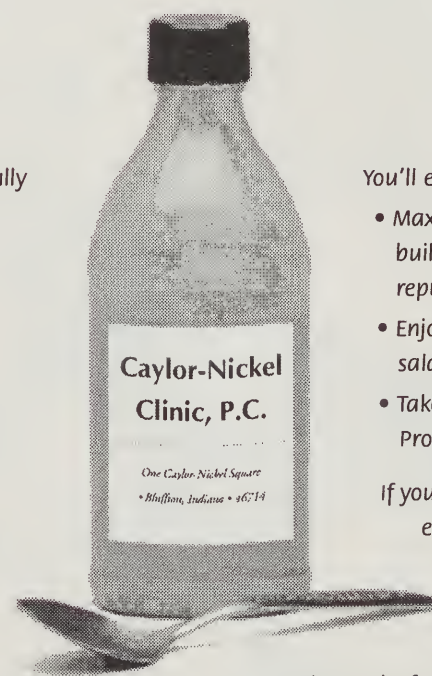
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Illinois House defeats

(Continued from page 1)

may lead to suspension or revocation of a doctor's license when appropriate."

"There would have been a lot of information in [the physician profile] that was intrusive and had nothing to do with the physician's capability to practice medicine or practice excellent medicine," said Nestor Ramirez, MD, a Champaign neonatologist and chairman of ISMS' Governmental Affairs Council. "It didn't look at the quality of the physician or the quality of the outcomes. It looked at if the person had a lawsuit." Medical

malpractice information alone fails to give the public a true picture of physicians' competence, particularly in high-risk specialties, in today's litigious health care marketplace, he said.

IDPR strongly opposed the bill, said Terry McLennand, the department's legislative liaison. "We're here to regulate professions and protect the public health. It's questionable whether [this] would have increased public protection and benefit to the public health to the degree that it would have offset the administrative costs."

The bill would have required the department to release information con-

tained in mandatory reports IDPR receives from hospitals, insurance companies and other organizations that outline if a claim had been settled or paid or if disciplinary action had been taken against a physician's practicing privileges, McLennand said. Under current law that information is only for the confidential use of the Medical Disciplinary Board, and H.B. 73 didn't adequately address those confidentiality restrictions. "We cannot extrapolate out the information without violating the confidentiality [of physicians]," he said.

The profiles would have included no information to balance negative conno-

tations associated with the medical malpractice data, McLennand said. For example, they would not have included a physician's education, specialty board certifications, number of years in practice, names of hospitals where the physician has privileges or appointments to medical school faculties.

The administrative costs to compile the profiles also would have been overwhelming, according to IDPR estimates. At a minimum, the amended version of H.B. 73 would have required \$225,000 annually to operate the program in addition to a start-up cost of \$261,000. An early version of the bill required IDPR to pay the state's 32,000 licensed physicians for time spent reviewing their own profiles. IDPR had estimated that if each physician spent two hours reviewing his or her profile, annual reimbursement would have cost about \$8 million. To reduce those estimated costs, H.B. 73 was amended to remove physician reimbursement, McLennand said.

The bill didn't provide a new source of revenue to fund the program's annual or start-up costs, McLennand said. Some likely ways to have raised money for the program would have been increases in physicians' \$300 licensure fee, which would have required a separate vote by the state Legislature, cash transfers of funds from other IDPR programs, or an increase in the state's general revenue funding, McLennand said.

H.B. 73 was modeled after a bill approved by the Massachusetts Legislature last year. Profiles created by that legislation include malpractice information, disciplinary actions taken by the state board or hospitals, and criminal convictions, according to Wayne Matson, profiles project coordinator for the Massachusetts Board of Registration in Medicine. Unlike the proposed Illinois system, however, Massachusetts includes data about physicians' educational backgrounds, specialties, licensure and published articles.

Matson said the department has received more than 51,000 telephone calls requesting profiles since the program began in November 1996. The development of a World Wide Web page containing the profiles has been delayed because of confidentiality concerns, he added. Five full-time staff members operate the Massachusetts program.

But IDPR operates much differently than the Massachusetts board, McLennand said. For example, Massachusetts is responsible for only that state's 27,000 physicians, but the Illinois department handles not only the state's 32,000 licensed physicians but also 470,000 other professionals in more than 39 different fields, McLennand said. He added that the Illinois cost estimates for the program failed to include the additional staff salaries that would have been necessary to operate the profiling system.

Much of the information that H.B. 73 sought to release was already available to the public, said IDPR spokesperson Maureen Squires. "Currently, we give out information on when a physician's license was issued, when it expires, as well as any kind of discipline that's been issued." Illinois Medicine regularly publishes IDPR's disciplinary reports for physicians licensed in this state, and those monthly reports are also available to the public on the Internet. The public can gain access to medical malpractice information through the court system, Squires said. ■

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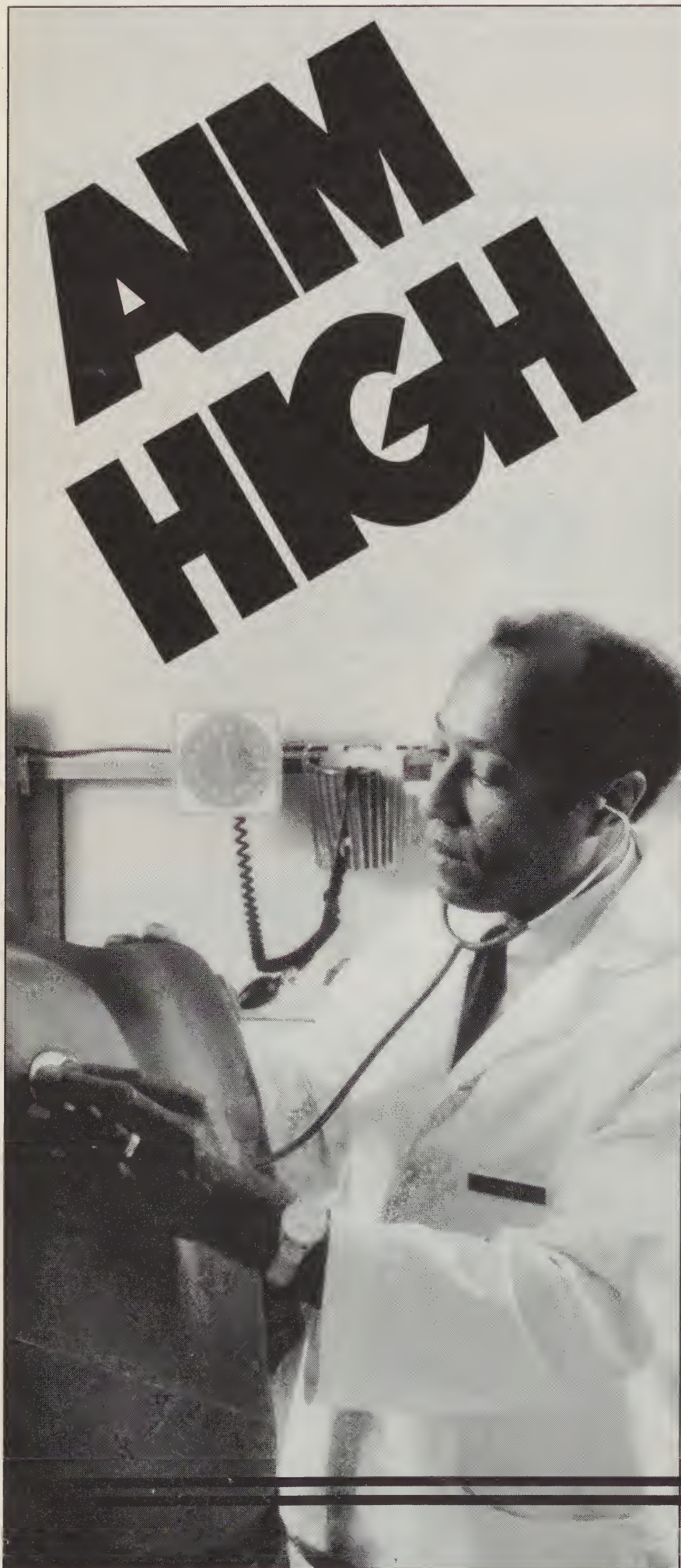
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Appellate court

(Continued from page 1)

Michael Colwell in the three-member court's unanimous opinion. "Instead, the Illinois Supreme Court has spoken on this issue, albeit over 60 years ago, and we cannot ignore that Court's rulings or that Court's definition of 'practicing medicine.' Accordingly, because the [Illinois] Supreme Court has found that a hospital's employing physicians constitutes practicing medicine and the agreement in the instant case involves the hospital's employing [John] Holden, MD, Dr. Holden's contract violates the corporate practice of medicine doctrine."

The case stems from a contract Dr. Holden signed with Rockford Memorial Hospital in May 1993 that barred him from practicing reproductive endocrinology in Rock County in Wisconsin, and Winnebago, Boone, Ogle, Whiteside, Lee, DeKalb, McHenry, Stephenson and Kane counties in Illinois for up to two years after the end of the contract.

WHEN DR. HOLDEN decided to leave the hospital in early 1996, he asked the courts to declare the noncompete clause unenforceable, arguing that the law related to the corporate practice of medicine prevents hospitals from practicing medicine and employing physicians. The trial court ruled in Dr. Holden's favor in June 1996, and the hospital appealed one month later. ISMS filed a brief in support of Dr. Holden's position.

"What the appellate court seemed to say is that the issue is not just one of employment of physicians, but also what constitutes the practice of medicine," said ISMS General Counsel Saul Morse. "Our view has always been a physician can enter into a management agreement, but clinical decisions can be made only by physicians."

Richard Haldeman, Dr. Holden's attorney, said, "I think Dr. Holden's contract is probably the best example of the corporate practice of medicine. In his contract, [the hospital] had such control over him that it considered patients to be hospital patients, not patients of Dr. Holden. Dr. Holden was simply the puppet who would provide the treatment. They would control the billing, and they owned the medical records."

The hospital has decided to appeal the decision to the state Supreme Court, according to Patricia King, vice president of legal affairs and general counsel for the Rockford Health System, of which the hospital is a member.

Although the trial and appellate courts ruled in Dr. Holden's favor, attorneys for both sides are waiting to see what the state Supreme Court decides in another challenge to the doctrine, the case of Berlin vs. Sarah Bush Lincoln Health Center, which made it there first. "We don't know when that decision will be coming," said Haldeman, who is with the Rockford-based law firm Haldeman & Associates.

The state Supreme Court listened to oral arguments for that case in March. The Berlin case began when Richard Berlin, MD, resigned in 1994 from the Charleston-based Sarah Bush Lincoln Health Center and began working one mile away for the Carle Clinic Association's Mattoon-Charleston branch. Sarah Bush Lincoln sued to prevent Dr. Berlin from practicing at Carle, based on his signing a 1992 employment contract

prohibiting his affiliation with "any person, firm or corporation engaged in competition with the hospital in providing health care services within a 50-mile radius" for up to two years after the contract had ended. Dr. Berlin eventually left Carle and set up private practice, suing the hospital for violating the ban on the corporate practice of medicine.

In April 1996, the Fourth District Appellate Court agreed with the trial court's ruling that the hospital's contract with Dr. Berlin was unenforceable.

A ruling to strike down an employment agreement doesn't prohibit hospitals from entering into management ser-

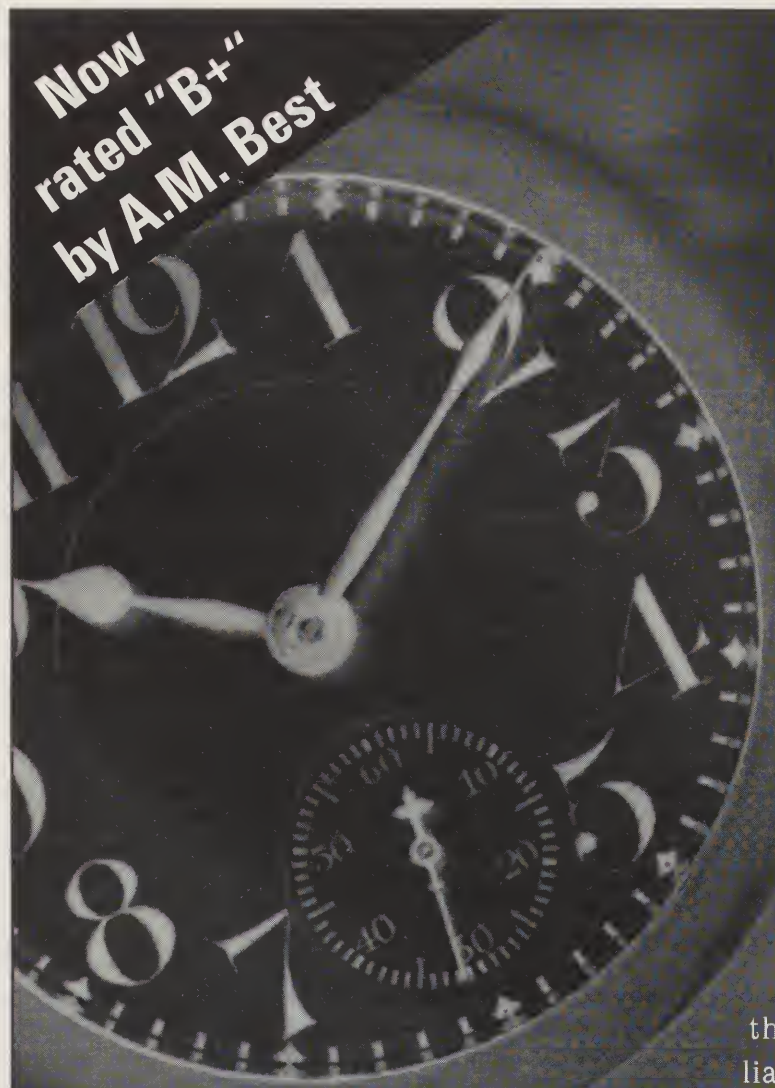
vices agreements with physicians, Morse said. Some arrangements with hospitals give hospitals less control of physicians' practices and require physicians to be more active in their own practices.

ISMS' House of Delegates policy states that if physicians are employed by entities made up of individuals not licensed to practice medicine in all branches and if the entities bill for services, the care provided may not be in patients' best interest.

State law exempts from the corporate practice of medicine any health care entities that are formed according to the Medical Corporation Act, the Profession-

al Service Corporation Act, the Health Maintenance Organization Act and the Voluntary Health Service Plan Act.

For now, the court decisions "tip the balance of power back to the independent practitioner and away from this corporate conglomerate where MBAs are dictating what medical practice should be," Haldeman said. But physicians need to be politically proactive on this issue before legislation is introduced to "clear the air," he added. "I would encourage all doctors to contact their state representatives and senators and tell them how they feel about the decision and what the practice of medicine should be." ■



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IS DROP 30 PERCENT BETWEEN '94 AND '96 (PAGE 6)



*What you say
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PAGE 7

Illinois Medicine

ILLINOIS STATE MEDICAL SOCIETY • MAY 23 1997

ISMS delegates
target changes
in IDPR
investigations
of doctors

PAGE 2

Managed care reform bill passes House

GENERAL ASSEMBLY: Incorporating much of ISMS' Managed Care Patient Rights Act, the bill heads to the Senate. BY JANE ZENTMYER

[SPRINGFIELD] After several hearings and months of deliberation, on April 25 the Illinois House passed a managed care reform bill, H.B. 626,

by a vote of 73-37. The measure now faces a battle in the Senate, which has just started its own subject matter hearings on managed care reform. (See

Senate story on this page.)

ISMS supports the bill because "it has been amended to include just about all the provisions we initially wanted with

the Managed Care Patient Rights Act," said ISMS President Jane Jackman, MD. "It's an extremely encouraging sign, and the fact that it had bipartisan support is also very encouraging. However, it's going to be a long, hard fight to get it through the Senate."

H.B. 626 is a compromise measure that incorporates concepts from MCPRA, which was developed by ISMS and didn't advance from the House, and concerns gleaned from hearings held by the House Health Care Availability and Access Committee. "When we began negotiations around this legislation every group was invited to the table," said Rep. Mary Flowers (D-Chicago), chairman of the committee and lead sponsor of H.B. 626. "It was never intended to satisfy one particular group."

Flowers' committee chose to advance a bill that is based on New York legislation and that incorporated the viewpoints of

groups with divergent interests in the managed care debate. Those groups included the Illinois Association of HMOs, hospitals, the Illinois Academy of Family Physicians and allied health professionals. In addition to ISMS, supporters of H.B. 626 include the American Association of Retired Persons, the Coalition for Consumer Rights, the Campaign for Better Health Care, various pharmaceutical manufacturers, the Illinois Pharmacists Association, the Illinois Nurses Association and the Coalition of Citizens with Disabilities in Illinois.

Like MCPRA, H.B. 626 addresses patients' rights in five basic areas: information, quality, choice, individual respect and advocacy. Under the measure, plans would have to give enrollees information such as descriptions of coverage provisions, utilization review requirements and payment methodology. (Continued on page 11)

H.B. 626 at a glance

H.B. 626, the ISMS-backed managed care reform bill passed by the House, would do the following:

- Require disclosure of plan information, such as coverage provisions and utilization review requirements, to enrollees and prospective enrollees.
- Assign implementation to the Illinois Department of Public Health.
- Create grievance procedures allowing patients to appeal plans' denial of medical services.
- Allow patients with life-threatening conditions or degenerative or disabling diseases to have standing referrals, as determined by the primary care physician in consultation with the patient and the plan, to specialists with expertise in treating those conditions.
- Prohibit plans from terminating or refusing

to renew physicians' contracts because doctors filed a complaint against the plan, appealed a plan decision or requested a due process hearing.

- Require reasons for contract termination or nonrenewal to be provided in writing.
- Ban gag clauses and incentive plans that would limit or reduce medically necessary and appropriate services.
- Require IDPH to develop and administer an annual patient satisfaction survey.
- Create the Managed Care Ombudsman Program to help consumers navigate the managed care system.
- Require plans to establish a board - whose voting members would include network physicians, providers and enrollees - to review all aspects of the managed care plan.
- Regulate plans normally exempt under the federal Employee Retirement and Income Security Act.

State Senate begins hearings on managed care reform

DEBATE: ISMS president urges comprehensive solution. BY JANE ZENTMYER

[SPRINGFIELD] While the Illinois House was winding up its debate on managed care reform before passing H.B. 626, the Senate's managed care subcommittee convened for the first time on April 23 to hear testimony from supporters and opponents of comprehensive managed care reform.

"I urge this committee to examine comprehensive solutions to the key question facing patients and their doctors today: In an era of managed care, what rights do patients have?" said ISMS President Jane Jackman, MD, in her testimony before the subcommittee. "Our answer is simple: Patients have a right to quality care from their managed care plans. If we uphold that principle, we can assure that in the move



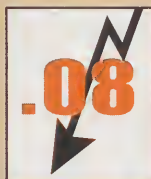
Dr. Jackman

to managed care, we rein in the cost of health care without losing respect for its value."

ISMS developed the Managed Care Patient Rights Act last year and after refining it, introduced it this session. The bill failed to advance from the House, but ISMS continues to support its basic patient rights in the areas of information, (Continued on page 8)

INSIDE

Gov. Edgar
considering lower
blood alcohol
limits



PAGE 3

New players
complicate
workers' comp
cases

PAGE 5

DEPARTMENTS

Classifieds9



John McNulty

ISMS DELEGATES Al Burdick Jr., MD (left), and William Gogan, MD, cast their votes on the floor of the House of Delegates at the Society's Annual Meeting last month. See page 2 for coverage of some of the resolutions passed by the House.



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ISMS delegates seek changes in state investigations of doctors

ANNUAL MEETING: New policies, positions encourage legislative action. BY JANE ZENTMYER

[OAK BROOK] The ISMS House of Delegates wants to change the way government agencies investigate physicians and the payment of legal fees in lawsuits, according to resolutions passed during the 1997 Annual Meeting in Oak Brook April 19-21. These were among the 20-

plus resolutions debated in Reference Committee D – which considered issues dealing with governmental affairs – before facing House debate and action.

Two resolutions aimed to restrict investigations initiated by the Illinois Department of Professional Regulation



Richard Frederick, MD, listens to reference committee testimony.

or any another governmental agency that receives charges or complaints about physicians. The first, which the House adopted, calls for physicians to be informed as soon as possible that any “gov-

ernmental or quasi-governmental public group” has initiated an investigation into their practice. The resolution also states

that physicians should be informed about the nature of the complaint and have the opportunity to respond before being formally charged. ISMS should also encourage other governmental agencies to adopt similar notification procedures, according to the position.

A second resolution asks ISMS to take steps including legal action to prevent IDPR from entrapping physicians during its investigations. “IDPR employees are going to doctors’ offices with false histories, seeking prescriptions from unsuspecting physicians,” according to the resolution, which also stated, “IDPR is suspending professional licenses for allegations of prescribing routine analgesics and minor tranquilizers to these imposters.” The House referred the issue to the ISMS Board of Trustees for study and report back at the 1998 HOD Annual Meeting.

The Board was also charged with studying two resolutions that recommend further tort reform. To deter frivolous lawsuits, both direct ISMS to develop legislation that would require losers of medical malpractice lawsuits to pay court costs. One of the two resolutions went further, asking for legislation to make contingency fees illegal as a payment mechanism.

The reference committee discussed five resolutions dealing with anti-smoking issues. The House chose not to adopt two: One urged ISMS to support the Food and Drug Administration’s regulation of tobacco as a drug and another called on ISMS to endorse anti-smoking strategies from the Agency for Health Care Policy and Research and to disseminate them to ISMS members.

Before turning down the resolutions, delegates said ISMS already supports public health education to prevent tobacco use. Also, delegates said AHCPH’s strategies may create new legal standards by requiring physicians to document that they asked patients at every visit whether they smoke and, if so, that they urged them to quit.

Of the three anti-smoking resolutions approved, one prevents ISMS from using the services of any lobbyists or political advisers who represent any tobacco company or firm, “since this represents a conflict of interest that cannot be reconciled.” The second requires the Society to inform members of the success, impact and disposition of anti-tobacco policies it has developed during the past 10 years and to identify more anti-smoking policies that would benefit the public and medical profession. The third resolution supports the Teachers Insurance and Annuity Association-College Retirement Equities Fund in its divestiture of tobacco stocks and encourages ISMS members at medical schools to inform their colleagues of this initiative. This resolution also calls for the submission of a similar resolution at the AMA’s next annual meeting.

Delegates also directed the Illinois delegation to the AMA to submit a resolution urging the expansion of the four-year pilot medical savings account program to include all non-Medicaid individuals and to be continued indefinitely. ■

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Correction

In the May 9 issue, a story on the Illinois Supreme Court’s acceptance of amicus briefs in the case of *Best vs. Taylor Machine Works* incorrectly identified the Brotherhood of Heat and Frost Insulators Local 17. We regret the error.

Lawmakers act on range of health bills

ROUNDUP: Legislators consider birth centers, required physician staffing at hospitals. BY JANE ZENTMYER

[SPRINGFIELD] As the General Assembly prepares to wrap up its spring session, several health-related bills have made their way through the legislative process. Those bills include the following:

LOWER BLOOD ALCOHOL LEVEL

On Gov. Jim Edgar's desk is S.B. 8, a bill that would lower the legal blood alcohol level from .10 to .08 for Illinois drivers. The Illinois House voted 106-11 to approve the bill, and the Senate passed it by a vote of 48-8. Lead sponsors were Rep. Tom Johnson (R-West Chicago) and Sen. Christine Radogno (R-LaGrange).

"There is enough scientific research out there now that definitely shows that driving is impaired at .08," Johnson said. Alcohol-related motor vehicle fatalities dropped by 13 to 17 percent in states that enacted the .08 standard, he added. "The bottom line in Illinois is that this will save lives."

The ISMS House of Delegates supports the decrease in the state's legal blood alcohol standard.

DEVELOPMENT OF BIRTH CENTERS

ISMS and the Illinois Section of the American College of Obstetricians and Gynecologists opposed H.B. 1828, which proposed the development of 10 birth center alternative health care models in a demonstration program. The House failed to vote on the measure by the April 25 deadline for House action on pending bills.

ISMS' House of Delegates supports the development of birthing centers only if they meet ACOG guidelines. ACOG is currently revising its policy to state that birthing centers located within a hospital complex provide the safest setting for labor, delivery and postpartum care. Gathering data about the safety of "free-standing" birthing centers has been problematic, according to ACOG. Although freestanding centers may be appropriate in rural areas, ACOG opposes them until reliable information about such centers can be studied.

H.B. 1828 failed to define the relationship between hospitals and birth centers, which could have led to freestanding sites that weren't equipped to provide emergency care and that wouldn't have met ACOG's revised policy. The Illinois Section of ACOG also noted that under H.B. 1828, most birth centers would have been built in larger metropolitan areas rather than in rural areas.

H.B. 1828 would also have encouraged a maximum 24-hour length of stay

for birth center patients and didn't specify any follow-up care. That provision conflicted with ISMS-supported legislation passed last year that requires insurers to cover a minimum 48-hour stay for women and their newborns following vaginal deliveries.

PHYSICIAN STAFFING AT HOSPITALS

On April 24, the House defeated H.B.

118, sponsored by Rep. Jan Schakowsky (D-Chicago), by a vote of 81-24. The measure would have required hospitals with 250 or more licensed beds to have at least one physician — in addition to any emergency room physicians — on duty at all times.

ISMS and the Illinois Hospital and HealthSystems Association opposed the bill. "The best doctor to treat a patient in an emergency situation is an emergency room doctor," stated IHHA's position statement. "If the objective of H.B. 118 is to treat emergencies outside the emergency room, having a pathologist or dermatologist on hand when

emergency surgery is required is not very useful."

DEFINITION OF MEDICAL STAFF PRIVILEGES

A bill pending before the Senate would define medical staff privileges outlined in the Hospital Licensing Act. H.B. 408 defines privileges as permission to provide medical or other patient care services and to use the existing hospital resources, like equipment and personnel, that are necessary to provide those services.

ISMS developed this measure, whose sponsors are Reps. Miguel Santiago
(Continued on page 8)

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EDITORIAL

Beating breast cancer

Traditional Mother's Day's gifts like flowers are well and good, but the American Cancer Society suggested something different this year: a greeting card with a non-Hallmark message. The Chicago office provided cards on request that could be sent to mothers, grandmothers, aunts, wives or sisters to encourage women to get a mammogram, which is still the best method of detecting breast cancer at its earliest stage.

If the cards sound a little extreme, consider the facts. Breast cancer is the most common cancer in the United States, and one woman in eight will develop this particular cancer in her lifetime. The ACS projects that in 1997, more than 9,200 Illinois women will be diagnosed with the disease and 2,000 are expected to die from it. Nationally, more than 180,200 women will be diagnosed with breast cancer, but 60 percent of women who are 65 and older don't have regular mammograms.

To help improve the statistics at the state level, the Illinois Division of the ACS teamed up with the Chicago Department of Public Health last month to train advocates at CDPH on breast health and breast screening. The advocates then went into Chicago neighborhoods to educate women. CDPH also extended the hours of its mammography facilities.

After years of debate on the issue and much public confusion, the National Cancer Institute recommended this spring that women in their 40s get mammograms every one or two years. The

institute also advised women who are at increased risk to seek guidance from their physicians on whether to start screening before age 40 and how often to have it done. Among high-risk women, regular mammograms could reduce the death rate from breast cancer by 17 percent, the institute said.

In Illinois, annual mammograms are covered for Medicaid recipients, and state law requires private health insurers to cover them. This session, a bill was introduced into the General Assembly that would require managed care plans to meet mammogram coverage requirements in the insurance code. ISMS supports H.B. 1330, which passed the House and was being considered by the Senate when this issue went to press.

ISMS House of Delegates' policy supports the American Cancer Society guidelines for breast cancer screening. In March, the ACS changed its recommendation for women in their 40s, advising mammograms annually instead of every one or two years.

The fact that there's still a slight discrepancy between screening guidelines from the ACS vs. those from the National Cancer Institute shouldn't distract us from the most important issue. About 97 percent of women in whom the disease is detected will survive if the cancer is caught early enough, according to the ACS. Our patients over the age of 40 need regular mammograms because screening saves lives.

PRESIDENT'S LETTER

The satisfaction of helping those in need

Jane L. Jackman, MD



Caring for patients regardless of their ability to pay is an essential part of being a professional.

"There is so much to be done, and we are the ones to get it done! Look forward to the deep satisfaction that will come from helping someone in need." – Gen. Colin Powell

In April, President Clinton held a summit on volunteerism in America. He was joined by three former presidents and Nancy Reagan, along with 4,000 community representatives from across the nation. Gen. Colin Powell chaired the meeting and will oversee the goals of the summit over the next three years.

Doctors are no strangers to the concept of volunteerism, often serving their local communities through schools, churches and service organizations, amongst others. However, the most crucial way that members of the medical profession can volunteer their time is by caring for the uninsured and the underinsured. In our country, Illinois is actually a leader in the number of free clinics, being second only to Virginia. At last count, we had 19, many of which were started by county medical societies and hospitals. In 1995, doctors saw more than 33,000 patients in this setting and gave away more than \$9 million-worth of care.

We are seeing an ever-increasing number of people in our state who lack health care insurance – at last count, 1 million, many of whom are children. With welfare reform, this number will likely continue to grow. I see the problem of the medically indigent as being a great opportunity for doctors and other health professionals to work together to make a visible difference in the health of their communities. No doubt we will have to look to government for a comprehensive solution to the uninsured, but I do not see this happening soon. In the meantime, if we all pitch in and help, much more than a dent can be made in the number of indigent patients cared for. In fact, if every ISMS member would take one hour each week to see four patients, more than 3.5 million patient visits a year would be counted!

As an active participant in the free clinic in Springfield, I can tell you

that the formation and operation of our clinic has drawn our community closer. People from many professions and all walks of life come together to help. The doctors who volunteer there also find the medical community is less fragmented and more collegial when they have a common project. The patients are uniformly appreciative, and many even give back by fund-raising and helping with the clinic's operation. The main problem, though, is that the need for services is always greater than what we can provide. Free clinics are constantly in need of more doctors to work at the clinics and to see patients on referral.

Some counties may be thinking of starting free clinics. In Illinois, we have a wealth of experience in starting them, so you don't have to reinvent the wheel! Blueprints are available from other Illinois free clinics. The Free Clinic Foundation in Roanoke, Va., even offers a how-to booklet. ISMS has sponsored two workshops on free clinics and also stands ready to help. It should be quite possible to get one up and running in six to 12 months if you use existing resources.

Free clinics are the most organized and visible ways for doctors to volunteer. However, the oldest and still the most common way is for doctors to quietly treat indigent patients in their own offices. The U.S. medical profession has a great, long tradition of providing pro bono treatment to those in need. Indeed, caring for patients regardless of their ability to pay is an essential part of being a professional. Now, more than ever, it is important that we carry on this tradition.

Volunteerism may not be the ultimate solution to the problem of the uninsured. In fact, there is probably no ultimate solution but only interim ones. However, the idea of a solution through volunteerism takes advantage of the fact that as doctors we are caring individuals. It uses a grass-roots approach to solve the health care needs in local communities without government help. Above all, it is a very human approach that relies on our willingness to care for one another as fellow human beings.

GUEST EDITORIAL

New players can complicate workers' comp cases

By Michael Treister, MD

The workers' compensation system has worked well for years, and I, like many other physicians, have found it to be fair and equitable as long as it isn't abused. But as insurance carriers become more concerned with reducing not only the cost of treating employee-patient injuries but also their time away from work, rehabilitation nurses or rehabilitation counselors hired by insurers are becoming more frequent visitors to physicians' and therapists' offices.

Recently, I saw a workers' compensation patient with a bucket-handled tear of the medial meniscus with a locked knee. I performed an arthroscopy and removed the locked piece of tissue. Because there wasn't much atrophy, I started the patient walking at the first postoperative visit with plans for him to return to work in two or three weeks. On the patient's subsequent postop visits – at three days, one week and three weeks – he was accompanied by a rehabilitation nurse sent by his insurance company to monitor the case. When a rehab nurse is with a patient, I see the patient first independently and then bring in the nurse, so that I can talk to the patient without interruptions and objections. Although I'm happy to explain treatment plans to patients, I resent wasting my time and resources in repeating the information and justifying myself to the rehabilitation nurse.

In the case I've described, I knew my treatment plan was in the best interest of the patient and his insurance carrier, and I resented the rehabilitation nurse's intrusion. She challenged my treatment plan, which could have undermined the patient's confidence in me and the physician-patient relationship, and that troubles me.

Such intrusions have become more common as insurance companies and employers try to bypass the Illinois Workers' Compensation Act to seek less-expensive care for injured employees. Unfortunately, patients are often poorly informed about decisions made about their care.

Insurance companies are now more likely to assign rehabilitation nurses or counselors to workers' compensation cases when their adjusters think treatment might cost too much or patients might be away from work too long.

Consider what state law allows: Injured workers can seek medical care from a physician of their choice, with referrals from two other physicians if the care is reasonable and customary and reflects a medical necessity. Employers and insurance carriers may try to guide employees to physicians with whom they've previously worked, and I think that's like the fox guarding the chicken coop. Often, there are good reasons why patients should not rely on their carriers' or employers' recommendations, such as if they think they're being pushed to return to work too soon or they believe care has been negligent.

Sometimes rehabilitation nurses can interrupt treatment. Far too often in slow-moving cases, I've seen patients

stop therapy with me because the nurses directed them elsewhere. I simply don't believe rehabilitation nurses have the background necessary to determine whether one therapist is better than another. If a patient is receiving adequate

care, why change the treatment mid-stream, hindering continuity?

I am not out to change the system, but I want to make sure the system isn't abused. Like many other physicians, I've found the workers' compensation system to work effectively and fairly if the rules are followed. The rules have been set up to protect patients and their treating physicians. They were not, however, created to force patients to change physicians or therapists for solely financial reasons.

There are some solutions, though. Physicians should better prepare themselves for working with these rehabilitation workers and should charge accord-

ingly if they are forced into rehabilitation conferences with them. In addition, doctors should try to prevent information they provide from being misquoted or misrepresented by providing photocopies of their progress notes.

By understanding how problems occur, we can begin to learn how to prevent patients from being caught in the middle.



Dr. Treister is a Chicago orthopedist and a member of ISMS' Medical Legal Council.



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REPORT for Illinois Physicians

MEDICARE

COVERAGE OF CERTAIN SURGICAL INTERVENTIONS FOR TREATMENT OF BREAST CANCER

Concerns have been expressed to the Health Care Financing Administration (HCFA) that efforts at cost containment may be resulting in women being required to receive surgical procedures on an outpatient basis in circumstances when such treatment is inappropriate. Concerns have also been expressed to HCFA about premature discharges for inpatient procedures.

HCFA has reviewed the available medical literature and concluded that caution is warranted in performing mastectomies or lymph node dissections. For many Medicare beneficiaries, advanced age, increased risk of post-surgical complications, presence of significant comorbidity, impaired functional status, and lack of social support may put them at increased risk if this surgery is performed in an outpatient setting or with insufficient hospital length-of-stay. The more extensive the surgical intervention (e.g., radical mastectomy), the more likely the patient is to be at increased risk from the procedure in the outpatient setting or from shortened length-of-stays. Given the current available evidence, it is not acceptable practice for providers or physicians to apply Medicare coverage policies indiscriminately to all beneficiaries by mandating surgical interventions for treatment of breast cancer in an outpatient setting or establishing a maximum length of an inpatient stay.

HCFA neither is requiring that all procedures be performed on an inpatient basis, nor establishing a minimum length-of-stay. In certain circumstances, with carefully selected patients, an outpatient setting or limited hospital stay may be appropriate. However, these practices may only be used when they have been determined to be appropriate by the patient and the patient's physician, after assessment of the individual circumstances.

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ISMIE Update

Civil suits drop 30 percent between 1994 and 1996

SURVEY: Tort reform enacted in 1995 results in decrease. BY CHRIS PETRAKOS

[CHICAGO] Civil lawsuits filed in Illinois' larger counties dropped 30 percent between 1994 and 1996, the years immediately before and after the enactment of state tort reform including a \$500,000 cap on noneconomic damages, according to a study released in March by the Illinois Civil Justice League. "This is a clear indication that tort reform is meeting one of its objectives," said ICJL President Edward Murnane.

The organization surveyed nine major Illinois court jurisdictions – Cook, DuPage, Kane, Madison, McLean, Rock Island, Sangamon, Will and Winnebago counties – representing about 75 percent of all civil filings in Illinois, according to the Administrative Office of the Illinois Courts. Murnane pointed out that because the selected counties use different recording procedures, the study focused on civil lawsuits seeking more than \$50,000 in damages.

The ICJL study looked at the number of suits filed in 1994, 1995 and 1996. Several counties experienced dramatic de-

creases in the number of suits filed from 1994 to 1996. In Rock Island County, for example, suits filed between 1994 and 1995 dropped only 1 percent but plummeted 66 percent a year later.

The situation was similar in Sangamon and Madison counties, where civil suits increased in both counties between 1994 and 1995 but a year later decreased 48 percent in Madison County and 50 percent in Sangamon County.

The suits filed in Cook County civil courts – where about half the state's civil suits are filed – fell by 27 percent between 1994 and 1996. The 13,367 civil suits filed in Cook County in 1995 equaled the total filings in all nine counties for 1996.

Among the counties surveyed, Winnebago appears to have been affected the least by tort reform. Civil cases dropped 3 percent from 1994 to 1995 and declined another 17 percent the following year.

A study conducted in 1992 by Northern Illinois University's

Center for Governmental Studies calculated that civil suits cost taxpayers an average of \$867 per suit and that Illinois spent more than \$58 million on court costs for the tort system. The study projected that a 30 percent reduction in suits filed would have saved more than \$17 million.

In 1992, defendants' legal fees and expenses for tort litigation amounted to \$531.6 million, according to the study. A 30 percent reduction in suits would have saved defendants \$159.4 million.

"Illinois residents believe strongly that there are too many personal injury lawsuits filed in our state, and the 1995 tort reform legislation is beginning to bring that under control – at a future savings of millions to Illinois taxpayers," Murnane said. "And not one injured person in Illinois has lost – or ever will lose – a single dollar in compensation for



Murnane

medical care, lost wages, job retraining or any of the other aspects of compensation that are necessary and proper in personal injury situations."

Murnane said he was surprised that the survey showed such dramatic results. "We knew immediately following the enactment of the new law that there would be a decrease, but I think the 30 percent across the board was somewhat surprising in that the impact is being felt so quickly."

Meanwhile, the Illinois Supreme Court continues to hear challenges to tort reform. On March 19, the court listened to oral arguments in *Kunkel vs. Walton*. That case challenges amendments to the *Petrillo* doctrine, which precludes physician defendants and their attorneys from ex parte communication with a plaintiff's former physicians unless the plaintiff's attorneys are present or have approved the communication. The tort reform law modified the doctrine so that plaintiff attorneys are required to provide written consent authorizing the release of their clients' medical records within 28 days of the request. Failure to provide the information can lead to a court order for the records or dismissal of the case.

The Illinois Supreme Court was expected to have heard oral arguments on May 21 in *Best vs. Taylor Machine Works*, a product liability suit from Madison County in which a trial court judge ruled the entire tort reform law unconstitutional and an appellate court concurred. On April 24, the state high court agreed to permit three amicus briefs to present plaintiffs' opposition to the tort reform law of 1995. Several organizations that support the law – including ISMS, the ICJL, the Illinois Manufacturers' Association and the Illinois Hospital and HealthSystems Association – have petitioned the court for amicus status but have been denied without explanation.

Murnane said observers of the two cases believe the court will conclude the *Best* case before ruling on *Kunkel*. A ruling on both cases may be issued simultaneously, probably in the fall, he added.

ISMIE seminar on MI set for May 31

On May 31, ISMIE will conduct a seminar at the Hyatt Regency Oak Brook Hotel on risk management issues related to myocardial infarction. The program will cover the causes of litigation, the screening and diagnosis of MIs, treatment modalities and risk management techniques for diagnosis and treatment.

In 1996, ISMIE's Internal Medicine Subcommittee was convened to address liability in internal medicine. After reviewing data from closed ISMIE lawsuits that resulted in payment of a settlement or judgment on behalf of ISMIE-insured internists within the last six years, the subcommittee found that a commonly litigated area involved the diagnosis and treatment of cardiovascular disease, especially myocardial infarction.

The subcommittee also reviewed data from the Physician Insurers Association of America and found that of the paid cases involving acute myocardial infarctions, AMI was one of most prevalent serious conditions resulting in high morbidity and mortality. Between 1985 and 1996, 2,045 claims and suits involving AMI were reported to PIAA. Of those, 38 percent of the claims resulted in indemnity payments, ranking the condition third in the amount of indemnity paid to plaintiffs, behind infant brain damage and breast cancer.

Research shows that problems in diagnosing and treating myocardial infarction are a leading cause of malpractice claims. ISMIE developed the MI seminar to help policyholders understand related issues and develop methods for preventing claims in this area.

Participants in the ISMIE seminar on MI can earn a maximum of 3.5 hours in Category 1 credit toward the AMA Physician's Recognition Award. The fee is \$50 per person for ISMIE-insured physicians and their employees and \$100 for all others. For more information, call the ISMIE Risk Management Division at (312) 782-2749 or (800) 782-4767, ext. 1327.

Lawsuits and medical malpractice premiums

Although the 30 percent decrease in civil suits filed in larger Illinois counties is a good sign, the results of the Illinois Civil Justice League survey do not translate into an automatic reduction in malpractice insurance premiums. The 1995 tort reform law should help stabilize premiums in Illinois, but that will take time, according to Harold Jensen, MD, chairman of the ISMIE Board of Governors.

An ISMIE analyst explained that a reduction in civil suits would not alone affect medical malpractice premiums. But if the number of civil suits – specifically medical malpractice cases – continues

dropping to the point that it is far below the national average, that could lead to premium stabilization or reduction.

Realizing the optimum benefits of tort reform will also depend on the Illinois Supreme Court's decision about the constitutionality of the law. In the product liability case of *Best vs. Taylor Machine Works*, a trial court judge ruled the entire tort reform law unconstitutional – a ruling upheld by an appellate court. The state Supreme Court is now considering the case and constitutionality issues.

Other factors besides tort reform can influence premium rates, however. Because of improved loss experience,

ISMIE policyholders in some specialties will experience rate reductions for the 1997 policy year. Ophthalmic surgeons and gastroenterologists will receive a 6.9 percent reduction; anesthesiologists, a 3.2 percent reduction; hand surgeons and gynecological surgeons, a 5.7 percent reduction; orthopedic surgeons who don't do spinal surgery, a 4 percent reduction; Ob/Gyns, thoracic surgeons and vascular surgeons, a 3.8 percent reduction; and cardiac surgeons, a 9.1 percent reduction.

No specialty has had a significant increase in losses that necessitates a rate increase.

Illinois Medicine will cover ISMIE rates in more detail in an upcoming issue.

'That's what I said – isn't it?'

ISMS Alliance speaker discusses how we develop our communication styles and how they can cause problems.

BY JANE ZENTMYER

What you say and what people hear you say can be two completely different things. Members of the Illinois State Medical Society Alliance got that message from communications expert Jane Sanders on April 18 at the ISMS Alliance Annual Meeting in Oak Brook. Sanders used this exercise to illustrate her point: Close your eyes and fold a piece of paper in half. Tear off the right corner. Fold it in half again, then tear off the left corner. Fold it in half again and tear off the right corner. Open it up.

Alliance members found that each created a different pattern. "I used the same words and same instructions for everyone in the same room, and look how many different patterns [you] have," said Sanders, founder of Marina del Rey, Calif.-based Empowerment Enterprises. "People perceive things differently, and when you add gender differences on top of them, it's no wonder we have communication problems."

Sanders said she believes male physicians tend to be poor communicators because men are naturally inclined to fix things and physicians are in a profession in which their job is to do just that. That means they may focus more on the end, or the solution, than on the process of communication that helps lead to the solution. That can cause communication problems between physicians and patients.

Physicians sometimes find that what they think they've told a patient about medications, diagnoses or treatments has not been understood as well as they had hoped. Illinois Medicine talked to some physicians about their perceptions of effective physician-patient communication.

As a general surgeon, Raymond Hoffmann, MD, said he sees patients who are often frightened from the moment they set foot in his office. He explained that he uses communication to help put patients at ease: "My personal goal is – no matter how bad the situation, especially if they're in the hospital – to try and leave the patient with a smile on his or her face, even if I have to tell a dumb story about me and my kids or something."



Sanders talks to Alliance members about the differences in what we hear and what we perceive.

Establishing rapport with patients, even during the limited time he has to spend with them, helps them feel more relaxed, Dr. Hoffmann said. He also tries to stay away from medical jargon to make sure patients understand what's going on. Physicians should try to "talk their language at the patient's level and not use fancy doctor words like 'pancreatoduodenectomy,'" he said. Instead, he suggested using patient-friendly phrases like 'take out a piece of the pancreas.'

As times have changed, so has physician-patient communication. In the past, some doctors used the approach, "I'm the doctor; this is what you're going to do; and you don't have any options," said Scott Reid, DO, a general surgery resident at Chicago Osteopathic Hospital and Medical Center. Nowadays, physicians sit down with patients and their families and offer a reasonable understanding of their disease process, Dr. Reid said. "A lot of it is trying to listen and find out what the patient wants from you."

MOST PHYSICIANS DEVELOP their communication style by learning from example during their training. Dr. Reid described his training: "The attending physicians in our program make a point of telling the residents, 'Look, you have to realize that as a future surgeon, you are being given the ultimate privilege. [Patients] are letting you take them to surgery and operate on them. That's the biggest compliment and biggest privilege somebody can give you in our field. In light of that, we're really there just to help them, and it's up to us to give them the information so that they can make an educated treatment decision.'"

In her presentation, Sanders said that people learn communication skills from their environment and circle of contacts, so there is great potential for differences. Some of those differences are instinctual, she added. For example, men and women have long played historical roles in the sociological "tribe," which has led to some inborn traits that affect communication styles. Male inborn behaviors include bonding through tasks and activities, finding it difficult to ask for help and speaking directly and to the point. Women tend to bond through feelings, ask for help and discuss problems in detail.

Misunderstandings can occur – particularly between men and women – because people listen and talk to each other using their own learned communication styles, Sanders said. "It's going to take men and women meeting halfway, adapting their behavior and their state of mind, their attitude, their perceptions." ■

Alliance expands anti-violence effort

The Illinois State Medical Society Alliance will continue its anti-violence work this year under a new theme: "Hands are for helping. Hearts are for caring. Save our families from domestic violence."

"We are trying to carry on what was started last year," said Julie Ringhofer, a Belleville resident who serves as the Alliance's new president. "I just widened the scope to include the whole family."



Ringhofer

Last year, the Alliance placed anti-violence messages on more than 30 billboards throughout the state to help educate the public about the effects of violence on children. This year's broadened campaign will include posters, too.

ISMS and the Alliance also sponsor a CME program to help physicians and other health care professionals identify and treat the victims of domestic violence. For more information about this two-credit Category 1 program, call (312) 782-2099.

The Alliance will also look at the possible harm to families posed by the Internet. Three regional meetings in Belleville, Bloomington and Joliet, which will replace the yearly fall meeting, will focus on dangers in cyberspace.

State Senate begins

(Continued from page 1)

advocacy, quality, choice and respect, Dr. Jackman told the committee. "While we recommend it to you wholeheartedly, we remain open to new ideas and more effective mechanisms for assuring our patients [their] health care rights."

Despite the House's passage of a reform bill, Sen. Thomas Walsh (R-Westchester) said in an interview after the House vote that the Senate is unlikely to take action until the fall at the earliest. The subcommittee plans to conduct hearings around the state this summer to

hear testimony from special interest groups and their grass-roots members.

"The bottom line is naturally going to be how we can make the managed care system better for people in the state of Illinois," Walsh said. "Reform isn't going to kill managed care, because I think everybody agrees it's a necessary option. Managed care is a cost-effective option that just needs a little bit of an overhaul at this time."

The Senate subcommittee also heard testimony from representatives of large and small businesses, the Illinois Nurses Association, the Illinois Association of HMOs and the Illinois Hospital and

HealthSystems Association.

Illinois Association of HMOs President Barbara Hill told subcommittee members that H.B. 1042, which the HMO association developed, proposed changes in the managed care industry that would not have increased health insurance premiums. Those changes included banning gag clauses, putting patient grievance procedures into law and requiring disclosure of some plan information. The IAHMO measure failed to advance by April 25, the deadline for House action.

In an interview after the hearing, Dr. Jackman addressed H.B. 1042. "This

industry bill would have done nothing to change the existing system that created many of the problems patients cite, like drive-through mastectomies and deliveries. It would have offered patients virtually nothing they didn't already have under existing law and practice." H.B. 1042 would have banned only some gag clauses and wouldn't have stopped such practices as physician deselection from plans based on patient advocacy, she said.

At the hearing, Hill said that MCPRA could have increased costs by requiring independent medical staffs to be part of managed care plans. The medical staff's recommendations would have limited the control of managed care plans: "The HMO could adopt them or not adopt them, but it could not in any way modify them. The HMO would not be allowed to set practice guidelines without this board's approval."

But Dr. Jackman told the subcommittee that independent medical staffs would ensure that physicians had a role in developing the medical policies that affected their patients' needs. "We strongly believe that plans working hand-in-hand with their practicing physicians will strengthen and improve managed care. Plans that adopt this model will make their customers – our patients and your constituents – more satisfied over the long run."

Under a model like the one in MCPRA, the relationship between an independent medical staff and a hospital would operate much like a hospital medical staff interacts with a hospital. The staff would consist of practicing physicians who were plan members and who would elect a medical review board. That panel would set the plan's medical policy, as well the procedures and criteria for utilization review, quality assurance, credentialing and medical management. "This would assure that doctors, not just insurance clerks, would have a voice in utilization review decisions," Dr. Jackman said. ■

Lawmakers act

(Continued from page 3)

(D-Chicago) and Mark Beaubien Jr. (R-Wauconda) and Sen. William Mahar (R-Orland Park). The House passed the bill on April 18 by a vote of 116-0, and the Senate Public Health Committee approved it by a vote of 9-0 on April 29.

PREJUDGMENT INTEREST ON JURY AWARDS

Despite the House Judiciary Committee's 6-5 passage of a bill allowing plaintiffs to collect prejudgment interest on jury awards, the full House failed to vote on the measure before the April 25 deadline. H.B. 628, sponsored by Schakowsky, would have altered the way interest is calculated on judgments, allowing interest to begin accruing on the date of the accident or negligent event, rather than on the date the jury handed down its verdict.

ISMS opposes the bill. "This bill could let manipulation unfairly increase the cost of defending a case by providing interest from the date of injury, which at times can be as many as eight years before trial ever occurs," said ISMS General Counsel Saul Morse. In addition, statutes of limitations stipulate that in some cases, plaintiffs have several years to file suits after incidents occur. Defendants would have faced interest payments that had stacked up for several years on top of the awards set by juries. ■

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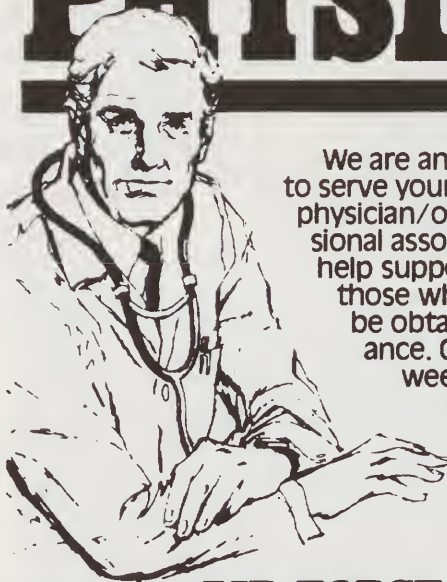
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Managed care reform

(Continued from page 1)

gies as well as the plan's most recent financial statement and the names of plan officials.

H.B. 626 goes a step further than MCPRA and places an assessment on managed care plans to fund a Managed Care Ombudsman Program. This program would help patients navigate the managed care system, select plans and understand their rights. It would seek to educate consumers and advocate for their interests rather than those of a particular health care provider or plan.

The measure requires the Illinois Department of Public Health to oversee quality and access issues related to managed care plans and the Illinois Department of Insurance to be responsible for only the plan's financial oversight.

We cannot be paying \$14 million salaries and sending women home within 23 hours of [hospital admission] or telling a woman that breast cancer [treatment] is outpatient surgery.



— Rep. Gwenn Klingler

MCPRA would have allowed enrollees with chronic conditions like asthma to have direct access to a "principal care physician," who would have been a specialist in that area and would have been required to be a plan member and have a referral agreement with the primary care physician. H.B. 626 allows primary care physicians to give enrollees who have chronic conditions a "standing referral to a specialist with expertise in treating" their conditions.

During debate on the House floor on April 25, Rep. Ann Hughes (R-McHenry) spoke against the due process provisions in H.B. 626: "What is the reason for requiring due process for terminating or nonrenewal of contracts when that is an item that can and rightfully should be part of the contract negotiations? How does this improve patient care?"

"So doctors can advocate on behalf of their patients," Flowers responded. H.B. 626 would ban not only gag clauses but also gag practices, requiring due process for physicians who were terminated from plans. The bill would also force plans to accept the liability associated with the activities of the plans, not just those of the participating physicians. Plans would also have to develop grievance procedures so that patients and their physicians could appeal plan decisions about treatment.

Also speaking during floor debate was Rep. Carolyn Krause (R-Mount Prospect): "As the minority spokesperson of the Health Care Accessibility and Access Committee, I, along with the other members, have had the opportunity to hear testimony from a number of witnesses on the importance of legislation to address the changing area of HMOs. The legislation that is before us today

comes about because of concerns expressed by constituents."

Opponents argued that H.B. 626 would increase insurance premiums and, therefore, the cost of doing business in Illinois. Citing statistics from the Illinois Chamber of Commerce, Rep. Terry Parke (R-Schaumburg) argued that the measure would be counterproductive because of an estimated increase in health insurance premiums of at least 12 percent. "When the bottom line comes down to whether [business owners are] going to keep the doors open or pay the premiums on health insurance, they are going to choose to keep their doors open. That

means they are going to drop their health insurance because it's gotten too costly."

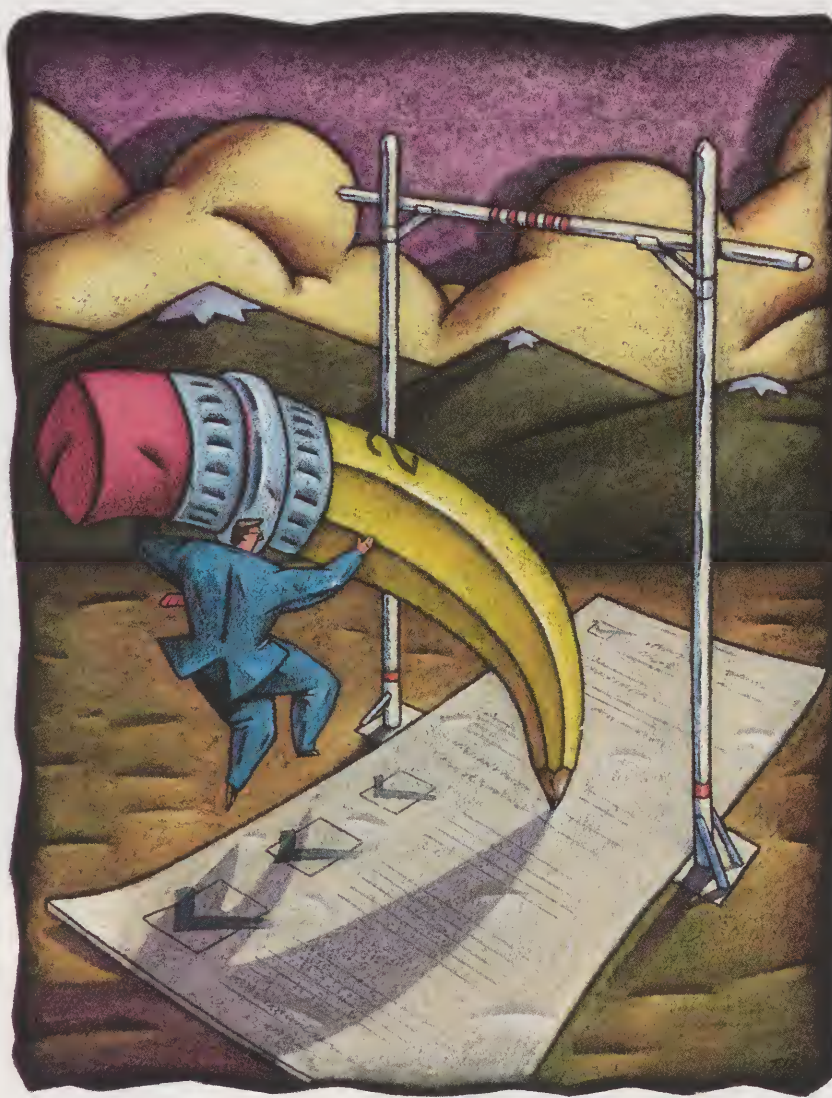
Flowers challenged the 12 percent estimate, however, charging that the chamber's figure had not been validated. In Texas, a similar managed care reform bill increased costs only 1 to 1.5 percent, Flowers said, adding, "This number comes from the Texas business group."


Rep. Gwenn Klingler (R-Springfield) noted that consumer magazines have reported that profits from managed care plans are often diverted to executive salaries. "These companies need regulations so that you get the care you want," she said. "We cannot be paying \$14 mil-

lion salaries and sending women home within 23 hours of [hospital admission] or telling a woman that breast cancer [treatment] is outpatient surgery."

Higher premiums aren't always justified, said Rep. Rosemary Mulligan (R-Des Plaines). "The plan is put together by the company. If there is any increase in premiums, the business community can stand firm and say that they don't believe there should be an increase." Even if there were a 1 to 1.5 percent increase, she said, "it's well worth it. What good is a benefit that an employee gets from an employer if it does not cover you when you are sick?" ■

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TER MEDICAL RECORDS (PAGE 7)

State hammering out CME requirements

PAGE 3

Illinois Medicine

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Obstacles to Schedule II
drugs keep pain
medication out of reach

PAGE 8

Amy Rothblatt



GOV. JIM EDGAR AND GRANDSON, DAKOTA, watch the action at the Y-ME Race Against Breast Cancer May 11 in Chicago's Grant Park. The race attracted more than 10,000 runners and walkers who raised more than \$500,000 to provide resources for women and families facing the disease.

IDPA seeks bids from HMOs Downstate

MEDICAID: State expands voluntary program. BY JANE ZENTMYER

[CHICAGO] For the first time, the Illinois Department of Public Aid will seek competitive bids from HMOs that want to serve Medicaid enrollees, expanding the program's voluntary managed care component to include most of Downstate instead of just Cook County.

"What we wanted to do was go statewide and do that through a competitive process," said George Hovanec, IDPA's administrator of the division of medical programs. "We wanted to have rates established by what the market would bear."

Contracts were previously awarded to HMOs if the organizations agreed to meet a set rate system, Hovanec said. The managed care option first became available in the 1970s but only to Medicaid recipients in Cook County. The voluntary program currently serves 180,000 Medicaid recipients enrolled in 12 HMOs.

"There was a desire on the parts of the HMO industry and certain Downstate communities

(Continued on page 11)

INSIDE

**Patients
have new
options under
Kassebaum-
Kennedy**

**S.B. 802
CHIP
Portability**

PAGE 2

**ISMS delegates
want changes in
managed care
procedures**



PAGE 10

DEPARTMENTS

**Malpractice
Roundup.....7**

Classifieds12

**IDPR
Disciplines14**

ISMIE maintains base rate for second consecutive year, lowers rates for some

MEDICAL MALPRACTICE: Improved loss experiences lead to decreased premiums. BY JANE ZENTMYER

[CHICAGO] On July 1, ISMIE will lower its medical malpractice insurance rates for 2,265 insured physicians in six specialties in addition to holding the 1997 base premium rate for the second consecutive policy year.

"This is another example of ISMIE's Physician-First Service philosophy in action," explained Harold Jensen, MD, chairman of the ISMIE Board of Governors. "Unlike some other insurers, ISMIE does not inflate its reserves. When policyholders improve their loss experience, we want to benefit them by reducing their premiums."

For the 1997 policy year, policyholders in the following specialties will experience rate reductions: cardiac surgeons, a 9.1 percent reduction; ophthalmic surgeons and gastroenterologists, a 6.9 percent reduction; hand surgeons and gynecological surgeons, a 5.7 percent reduction; orthopedic surgeons who don't do spinal surgery, a 4 percent reduction;

thoracic surgeons, vascular surgeons and Ob/Gyns, a 3.8 percent reduction; and anesthesiologists, a 3.2 percent reduction.

If the 1995 tort reform law is upheld by the Illinois Supreme Court, that could help stabilize premiums in Illinois in the future, but for now, other

factors brought about ISMIE's lower rates.

ISMIE's medical malpractice insurance base rate is predicated on the company's anticipated losses for the coming year, the number of insureds covered and the average amount each must

(Continued on page 11)

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On July 1, physicians can also decrease their specialty ratings without a premium charge by discontinuing the performance of certain procedures. For example, ratings can be decreased by an Ob/Gyn who gives up obstetrics or a family physician who forgoes surgery.

Previously, only physicians who were 55 years old and had been insured with ISMIE for five consecutive years could take advantage of this option.

For more information about these or other ISMIE products, call (800) 782-4767.

Illinois Nursing Act slated for renewal

SCOPE OF PRACTICE: Debate focuses on statutory recognition of advanced practice registered nurses. BY JANE ZENTMYER

[SPRINGFIELD] With the Illinois Nursing Act set to expire at the end of this year, bills have been introduced to update the law with a new recognition of advanced practice registered nurses.

"ISMS supports advanced practice nursing but believes that APRNs should function in collaboration with physicians, not separately," said Joan Cummings, MD, chairman of ISMS' Council on Education and Health Workforce. "The Medical Society does not support the independent practice of medicine by nurses."

The term "advanced practice registered nurses" encompasses four groups of nurses: nurse

practitioners, certified registered nurse anesthetists, certified nurse midwives and clinical nurse specialists.

H.B. 1076, already passed by the Illinois General Assembly and awaiting the governor's consideration, would extend the sunset date for the Illinois Nursing Act to Jan. 1, 2008. Rep. Carol Ronen (D-Chicago) and Sen. Robert Madigan (R-Lincoln) sponsored the bill,

which does not address the APRN issue.

Two other bills, H.B. 1078 and S.B. 606, also sponsored by Ronen and Madigan, would add APRNs to the Illinois Nursing Act, but as this issue of Illinois Medicine went to press, neither bill had advanced from its originating chamber. ISMS opposes the definition of APRNs and the scope of practice. (Continued on page 15)

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INSURANCE: A measure on the governor's desk would implement Kassebaum-Kennedy in Illinois. BY JANE ZENTMYER

[SPRINGFIELD] The Kassebaum-Kennedy bill became federal law last year amid much discussion about the need to expand Americans' access to health insurance and limit exclusions for pre-existing conditions. But at the threshold of the law's July 1 effective date, physicians and patients have questions about how the law will be implemented and will apply to them.

"In most people's minds a portable television is one you pick up and move around. [Portability means] you pick that thing up and move it," said Madelynne Brown, assistant director of the Illinois Department of Insurance. "Many people are understanding that portability in health insurance [means] 'I can take the same health insurance with me when I leave.' That's just not the case. What it is giving you is the opportunity to get it somewhere else."

The Illinois Health Insurance Portability and Accountability Act, which makes the necessary changes in state law to implement Kassebaum-Kennedy in Illinois, overwhelmingly passed by the General Assembly this session and was on Gov. Jim Edgar's desk as this issue of Illinois Medicine went to press. S.B. 802, in keeping with federal law, sets requirements that state residents must meet in individual and group insurance markets to qualify for health insurance without pre-existing condition exclusions.

To implement Kassebaum-Kennedy in the state's individual insurance market, Illinois chose an "acceptable alternative mechanism" that was offered in the federal law. Illinois' S.B. 802 gives anyone who qualifies for coverage under Kassebaum-Kennedy, defined as "federally eligible" individuals, the opportunity to get insurance without a pre-existing condition exclusion through the Illinois Comprehensive

sive Health Insurance Plan, said Richard Carlson, CHIP's executive director.

Because CHIP must accept all federally eligible individuals, this mechanism exempts private insurers from having to do the same. Once policies have been issued, however, private insurers must continue renewing them without imposing pre-existing condition exclusions, Brown said.

"It's important for physicians to talk this over with their patients," said Janis Orlowski, MD, ISMS Third District trustee and a member of the CHIP governing board. Dr. Orlowski noted that the CHIP plan allows patients to choose their own physicians. People in transition need to be careful about their health insurance and recognize that Kassebaum-Kennedy may change their health insurance and their payment, she said. "Physicians and patients have to be aware that there's a difference between what the press has touted as a continuation of insurance and what the actual bill tells you."

People who apply for coverage in the individual market have usually left a job with group coverage to become self-employed, taken early retirement or been laid off. To become and remain federally eligible in this market, patients must have no other group coverage or Medicare or Medicaid coverage and must first exhaust any COBRA coverage. They must also accumulate at least 18 months of credible health insurance coverage without a 62-day break.

"This is a situation where time is of the essence," Carlson said. For example, when COBRA coverage expires, people have only 62 days to become covered by another health insurance policy before they lose their federally eligible status. "The most important thing to do here is plan ahead and start taking action before

Talk to me

Topics that Americans want their doctors to discuss with them



Diet, weight, fitness - 60%

Cancer - 60%

Heart or circulatory disease - 56%

Stress - 55%

Aging - 48%

Source: The Public Pulse, August 1996

their COBRA expires," he explained. "They're going to have to pay attention to the deadlines imposed on them."

Carlson recommended that people begin applying to several health insurance plans a few months before their COBRA expires. On June 1, insurers began giving former enrollees certificates that verify their months of credible coverage. People should save those certificates to use as proof of federal eligibility during their search for insurance in the individual market.

State and federal rules don't regulate the health insurance premiums that can be set by private insurers, but for some individuals premiums may be cheaper through private insurers rather than CHIP, Brown said. State law allows CHIP premiums to cost between 125 and 150 percent of what similar private insurance would cost. At least initially, CHIP premiums for those who are federally eligible will average about \$330 per person per month, which is about 135 percent of rates in the private market. "It certainly makes sense to shop," Brown added.

For individuals with pre-existing con-

ditions, however, CHIP may be the only option, Carlson said. Applications to CHIP will be revised to reflect changes in the federal law, and until new applications become available, applicants can use existing CHIP applications, Carlson said.

Carlson said that another federal eligibility requirement that might create problems is that a person's last insurance policy cannot have terminated for non-payment of premiums. Many people change insurance plans and stop making payments without informing their insurers of their desire to terminate the policy, he explained. "You want to be careful that you don't let your coverage run out, not pay the renewal premiums and then seek to get other coverage, because if your prior coverage terminates for non-payment of premiums, you lose the benefits of this federal law."

Those people who are in the process of exhausting their COBRA coverage may call CHIP at (800) 962-8384 for more information. Any other questions should be referred to the Illinois Department of Insurance at (312) 814-2427 or (217) 782-4515.

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Matt Ferguson

GRACE COWLES (CENTER) grimaces as Caitlin Adams, RN, prepares to inoculate Cowles' daughter, 17-month-old Carly, during the April 22 walk-in immunization clinic at the DuPage County Health Department in Wheaton.

State still hammering out details of new CME requirement

RULES: New Medical Practice Act goes into effect July 1.

BY JANE ZENTMYER

[SPRINGFIELD] Even though the revised Medical Practice Act becomes effective July 1, all the procedures may not be in place to enforce the changes.

One change is the requirement of at least 50 hours of continuing medical education per year as a condition of renewal of medical licenses. Exactly what constitutes CME credit has not yet been defined. As this issue of Illinois Medicine went to press, the Illinois Department of Professional Regulation was crafting rules to carry out the CME requirement.

"We're working with the Illinois State Medical Society, our various boards and medical personnel to come up with the rules," said IDPR spokesperson Maureen Squires. "Eventually, after we have the procedures down, we will notify all active physicians in Illinois."

The department does not have a deadline for completion of the rules, she added. "Obviously we're not going to impose unrealistic requirements that can't be complied with," Squires said.

Joan Cummings, MD, chairman of ISMS' Council on Education and Health Workforce and a member of the state's Medical Licensing Board, had some words of reassurance for physicians. The new Medical Practice Act doesn't call for retroactive CME requirements, she said. Although the act goes into effect July 1, physicians will not renew their licenses until 1999. The rules will likely be "prorated" to accommodate the addition of a new CME requirement in the middle of a licensure cycle, Dr. Cummings explained.

The Medical Practice Act of 1987 was scheduled to expire at the end of this year. ISMS worked with IDPR on the revisions for about a year prior to its passage in December 1996. The act reflects the work of ISMS and physician-supportive lawmakers in such achievements as maintaining the current \$300 fee to renew a three-year medical license.

The revised Medical Practice Act requires physicians to respond in writing within 60 days of notification that the Medical Disciplinary Board has received a mandatory report. It also defines "immoral conduct" as grounds for discipline. The law allows IDPR to place information on the state World Wide Web site regarding whether physicians have had disciplinary actions against them.

There was a CME requirement in the previous Medical Practice Act, but it didn't specify an exact number of hours, Dr. Cummings said. Without specifics, the

law was difficult to enforce, she added.

The ISMS House of Delegates approved a resolution at the Annual Meeting in April that urges IDPR to include the AMA's Physician's Recognition Award as proof that physicians have met the state's 50-hour requirement.

To receive the Physician's Recognition Award, doctors must earn 150 CME hours during a three-year period. The standard AMA PRA certificate requires 60 hours of Category 1 and 90 hours of Category 1 or 2. A certificate with "commendation for self-directed learning" requires 60 hours of Category 1, 60 hours of Category 2 and 30 hours of Category 1 or 2, according to the AMA.

Dr. Cummings said many physicians incorrectly believe the new CME requirement calls for all Category 1 credit. In fact, she said, "it would be a mix of hours that currently are defined as Category 1 or 2."

In working toward the AMA's PRA, Category 1 credits can be earned through formal learning activities offered through state medical societies and organizations that are accredited by the Accreditation Council for Continuing Medical Education. Category 2 credits come from less-structured experiences such as taking self-assessment exams and reviews, publishing medical articles and teaching medical and other health care professionals.

Physicians who have questions about the CME requirement may contact ISMS' Education and Licensure Division at (800) 782-ISMS or (312) 782-1654, ext. 1165. ■



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REPORT for Illinois Physicians

Smoking Cessation

Tobacco Smoking continues to be recognized as a major health risk in this country contributing to more than 400,000 deaths from Chronic Obstructive Lung Disease, Lung Cancer, Heart Disease and Stroke. Smoking has also been variously linked to such additional conditions as Pancreatic Cancer and Breast Cancer. The risk associated with tobacco smoking not only effects the primary smoker but also extends to the victims of second hand smoke.

Direct medical costs are estimated to be as high as \$50 Billion per year with an equal amount attributed to indirect costs including those related to lost productivity and to disability payments.

Motivating a patient to stop smoking and to remain abstinent continues to be one of the most difficult tasks facing both primary care and specialty care physicians. In recognition of this difficulty and of the consequences of smoking as noted above, the agency for Health Care Policy and Research (AHCPR) has developed clinical practice guidelines that can be utilized in smoking cessation efforts in caring for both adolescents and adults. All physicians are urged to follow the steps summarized below in the daily office care of adolescents and adults:

1. Ask and record tobacco-use status of every patient.
2. Every person who uses tobacco should be offered cessation advice at every visit. The repeated advice should be documented in the medical record. Physician-patient cessation discussion even as brief as three minutes are effective.
3. If the patient is willing to cease tobacco use, provide assistance.
 - a. Set a Quit-date
 - b. For selected patients, offer nicotine replacement therapy and/or social support group therapy. Recommendation to more intensive treatment programs can produce long-term abstinence.
4. Medical offices should make institutional changes to identify systematically and intervene with all tobacco users at every visit. Follow-up of patients attempting to quit, using the medical record, should also be systematic.

Copies of the AHCPR Smoking Cessation Clinical Practice Guideline are available through 800-358-9295, and on the Internet at (<http://www.ahcpr.gov/guide/>). AHCPR also publishes a short consumer version, "You Can Quit Smoking" in Spanish and English.

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EDITORIAL

Judicial fairness

Early on, we learn that life isn't fair. But we do expect fairness in the judicial system. So, where is the fairness in the process leading up to the Illinois Supreme Court's consideration of the case of Best vs. Taylor Machine Works, which challenges the constitutionality of the entire 1995 tort reform law?

Before hearing oral arguments on May 21, the Supreme Court allowed three joint amicus briefs that support the plaintiffs in the case. Of course, all Illinoisans have the right to access the courts. But on the defendant side, the Court denied all motions to file amici, including a request from ISMS.

In 1975, the General Assembly passed most of ISMS' tort reform proposals including a \$500,000 cap on all damage awards in medical malpractice cases. The Supreme Court later struck down the cap, but it accepted amicus briefs from both sides before making its decision.

In 1985, the General Assembly approved a bill including all ISMS' tort reform proposals except a cap on noneconomic damages and limitations on recovery for wrongful death. In a constitutionality challenge, the Supreme Court again accepted amicus briefs from both sides.

Why then in 1997 is only one side being given the opportunity to be heard?

In another unsettling development, the Illinois Supreme Court wrote a majority decision using the "loss of chance doctrine" in the case of Holton

vs. Memorial Hospital. Central to the doctrine is "proximate cause," which involves a direct relationship between a cause, or a defendant's conduct, and an effect, or a plaintiff's resulting injury. Previously, plaintiffs had to prove defendants' carelessness, their own injury and proximate cause by a "preponderance of the evidence," a probability of more than 50 percent. So, if a treatment had less than a 50 percent success rate, its failure to be administered could not have established proximate cause or a preponderance of evidence.

The recent decision said there is sufficient evidence of proximate cause in medical malpractice cases if plaintiffs prove to a reasonable certainty that a defendant's negligence deprived them of any chance of recovery. For example, if a patient with breast cancer was deprived of a bone marrow transplant that had a 20 percent success rate and that patient dies, the lost chance of surgery could be considered the proximate cause in the death.

The dissenting opinion stated that this ruling permits cause to be decided in a jury trial when there is no evidence of "reasonable probability" that negligence caused the injury. It also said that using the doctrine in only medical malpractice cases is unfair, since it could rightly be applied to other malpractice cases.

We hope that despite recent events, the decision-making process in the Best case will reflect fairness in considering both sides of the issue.

PRESIDENT'S LETTER

Legislation should help prevent abuses in genetic testing

Jane L. Jackman, MD



Patients should not feel pressured into forgoing genetic testing simply because of fears of loss of privacy and discrimination.

Genetic testing promises us the opportunity to detect hereditary predisposition to disease. Tests are currently available for genetic perceptibility to breast and ovarian cancer and Alzheimer's disease. The Human Genome Project reports the discovery of new genes almost weekly, and it may even reach its goal of sequencing all DNA in the human genome before the target date of 2005. Our hope is that this knowledge will aid us in the prevention and early detection of and possibly even the cure for genetic ailments. Our concern is for the potential abuse of our patients' genetic data through confidentiality issues and discrimination by insurance and employers, as well as patients' difficult decision-making about marriage and reproduction. Rep. Cliff Stearns (R-Florida), who leads the U.S. Commerce Committee's Genetic Task Force, stated, "This could possibly be the civil rights issue of the next millennium."

Although genetic testing is not yet widely available to the public, no doubt it will become so quickly. As doctors, we will have to become adept and knowledgeable at responding to patients' requests by counseling them about the risks and benefits. Recent studies show that the public is concerned about the potential misuse of genetic information. In February, an AMA study of 1,000 people showed that although 75 percent of the group would like to be tested for specific genes, 81 percent would be concerned about the privacy of that information.

Similar results came from a study of members of a genetic disease support group surveyed by researchers from Harvard, Stanford and the University of Massachusetts. Of the 917 members of the group, 455 believed that they were currently subject to genetic discrimination by organizations such as employers, insurance companies and schools.

The Kassebaum-Kennedy bill, or the Health Insurance Portability

and Accountability Act, does provide some protection for patients regarding genetic information, but it doesn't go far enough. It only prevents group health plans from using genetic information to determine insurance eligibility and to set pre-existing conditions exclusions. It does nothing to help people who have individual insurance policies or no insurance. Moreover, it does not protect those who move from group insurance to individual insurance from paying sky-high insurance rates if they have a genetic predisposition to disease. We are currently seeing a flurry of bills in Washington to close these loopholes.

Illinois is one of a growing number of states to pass a bill guaranteeing genetic privacy. "The bill will keep DNA tests a personal thing," said Rep. Donald Moffitt (R-Galesburg), the bill's House sponsor. The bill also passed unanimously in the Senate in mid-May and has been sent to the governor's desk. Under the bill, health insurance companies and employers could not discriminate against people on the basis of genetic tests, although life insurance companies are excluded from the bill. The measure should encourage patients who could benefit from genetic testing to proceed without fear of discrimination.

Insurance is by its very nature a gamble, and we need to continue to discourage companies from cherry-picking. Moreover, preventing the abuse of genetic information in determining insurance rates and eligibility will not change the current risks of insurance companies. Patients should not feel pressured into forgoing genetic testing simply because of fears of loss of privacy and discrimination. Genetic testing no doubt will revolutionize medical practice in the next century. Illinois has taken a very positive step to safeguard the privacy of genetic information through this bill. We will encourage Gov. Edgar to sign this significant pro-patient legislation.

GUEST EDITORIAL

Time to reinforce fight against teen smoking

By Ellen Goodman

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Not that Bennett LeBow is my wish come true. He isn't even my dreamboat. But when the head of the Liggett Group's holding company 'fessed up in public, I was reminded of that moment in "Liar Liar" when Jim Carrey finds himself transformed by his son's birthday wish. He is suddenly and hilariously unable to tell a lie.

It's now more than a week since LeBow came clean with his startling revelation of the obvious. Flanked by 22 state attorneys general, his company acknowledged that tobacco is addictive, causes disease and is targeted to kids. The Page 1 shocker was "Tobacco Company Tells Truth!"

This wasn't an act of repentance but of survival. This "Liar Liar" had to throw some fire extinguisher on his pants to save the company. Like a small-time drug dealer, he essentially turned state's evidence against the other, bigger tobacco co-conspirators and cut a deal to protect Liggett from large liability suits.

Nevertheless, LeBow better have somebody else start his car for a while. Liggett's agreement to hand over documents of plotting tobacco execs talking about their "habit-forming drug" and "addicts" is likely to make a giant crack in the stonewall defense of the remaining companies. Now a series of cases – from a wrongful death suit in Florida to a Medicaid reimbursement suit in Mississippi – are all going to be piggybacking on the Liggett revelations. The Federal Trade Commission has hinted they're ready to use this information to ride Joe Camel off into the sunset.

Even Dick Daynard of the Tobacco

Litigation Project, who has seen the tobacco lawyers make lemonade of every lemon, agrees that this looks a lot like the beginning of the end.

And that raises the musical question: What is the end anyway? What is the endgame? What does the Liggett deal have to do with finally stomping out the most serious health hazard in America? The end is not to ban tobacco. Not even the most ferocious anti-smoking activist wants to turn cigarettes into a new class of illegal drugs and turn smokers into criminals.

This fact is what has made the anti-smoking campaign the most complex public health issue since the surgeon general declared cigarettes were hazardous to your health. We have a product that kills people and can't be taken off the market. Every health strategy is devised around this conundrum.

What happens next? The endgame won't be played out with bigger and badder labels. We have been to that briar patch. At this point, the only warning on a cigarette pack that might make a smoker pay attention would be full color reproductions of Jack Kevorkian's ghoulish oil paintings.

The state lawsuits to get tobacco companies to ante up for the health costs also have a nasty flaw. Tobacco may save the government money by killing people younger and cheaper. In a true fit of chutzpah, tobacco lawyers have turned this into what is fairly called "the euthanasia defense." As for, uh, moral suasion or the pariah effect? Not even LeBow intends to quit the butt biz. As Daynard says, "There's almost no evidence that tobacco executives are capable of shame."

The public health campaign hasn't failed. It's succeeded – not just by sending smokers onto the window ledges – in



"Give me your money or I'll force you to smoke a cigarette."

getting us to this Moment of Truth.

But the only way to phase tobacco out is by cutting off access to new young customers. The value of the Liggett agreement is that if the tobacco companies can't lie, they can't win in court. If they can't win, they'll have to pay. That means cutting profits or raising prices. And one sure-fire way to cut teen smoking is by making it more expensive.

The real endgame now is to push the companies into a corner from every direction. As Daynard lays it out bluntly, "We want them to be able to supply the addicts, but there is no reason to allow the pushers to snare more people in their web."

This means plain packaging, a ban on marketing, higher prices, and keeping kids' hands off the cigarette packages. It also means getting the message across. So far the anti-smoking efforts aimed at kids have reinforced the alluring message that smoking is for grown-ups. The teen rate of smoking is actually going up.

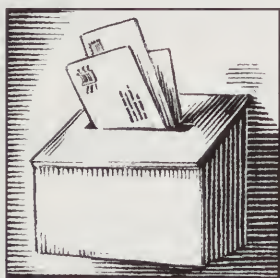
We need a strategy, like the tough new California ads, to convince teens to rebel. Rebel that is, against manipulation by the tobacco folk. After all, as Harvard's William De Jong says, it's time the kids saw the tobacco folks as "the geeks in blue suits." Now, that's truth in advertising.

LETTERS

Trouble with a term

I'd like to preface my comment on the partial-birth abortion material covered in the April 11 issue by affirming my total support of the ISMS Board of Trustees in supporting a ban on this procedure. My problem is with the use of the term "intact dilatation and extraction."

As a linguistic purist, I see the word "intact" as an adjective defining the noun "dilatation" as a space or a canal, according to Webster's Unabridged Dictionary. Now that may seem insignificant to the lay public, but when organized medicine uses the same phrase, it permits opponents



in the debate to refer to D&X as casually as one uses the term D&C. But the use of the term D&X is accompanied by gruesome photographs and lurid details, which add fuel to the already explosive mixture.

We do not correct misinformation with the use of a catch phrase; we simply muddy the waters. Finally, I would be happy if someone could explain to me what a "partial-birth abortion" is. I think of it as simply the termination of a late pregnancy.

— Alex S. Tulsky, MD
Chicago

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Annual Meeting highlights

AT RIGHT, NEW ISMS HOUSE OF Delegates Speaker John Schneider, MD (left), and outgoing House Speaker Richard Schmidt, MD, consider a resolution being debated on the House floor at the Annual Meeting in Oak Brook in April. At lower left, newly elected Vice Speaker William Kobler, MD, and his wife, Carolyn, enjoy President's Night entertainment. At lower right, newly elected Fourth District trustee Rodney Osborn, MD (left), and Third District trustee Edmund Donoghue Jr., MD, wait for their turn at the microphone.



Delegates elect officers, trustees

[OAK BROOK] Richard Geline, MD, an orthopedic surgeon in Skokie, was elected ISMS president-elect April 20 at the ISMS House of Delegates Annual Meeting in Oak Brook. Springfield family physician Jane Jackman, MD, was installed as president during the meeting.

Other officers are First Vice President Clair Callan, MD, Abbott Park; Second Vice President Aldo Pedroso, MD, Chicago; Secretary-Treasurer Chester Danehower Jr., MD, Peoria; and Chairman of the Board of Trustees M. LeRoy Sprang, MD, Evanston. John Schneider, MD, Chicago, is the new speaker of the HOD, and William Kobler, MD, Rockford, is vice speaker.

The House elected the following

trustees to the board: Phillip Boren, MD, of Carmi; Dennis Brown, MD, Schaumburg; Charles Drueck III, MD, Evanston; Peter Eupierre, MD, Oak Park; Earl Fredrick Jr., MD, Chicago; Raymond Hoffmann, MD, Rockford; Janis Orlowski, MD, Chicago; and Rodney Osborn, MD, Peoria.

Robert Oliver, MD, Springfield, was named as the representative to the Board for the Resident Physicians Section, and Scott Preusen, a student at Southern Illinois University in Springfield, will represent the Medical Student Section.

Delegates to the AMA elected to serve from January 1998 to December 1999 are Albino Bismonte Jr., MD, Gurnee; Alfred Clementi, MD, Arlington Heights; Joan Cummings, MD, Hines; Jere Freidheim, MD, Chicago; Silvana Menendez, MD, Belleville; Patricia Merwick, MD, Elmhurst; Sandra Olson, MD, Chicago; Dr. Sprang; Arthur Traugott, MD, Champaign; and Ronald Welch, MD, Belleville.

Alternative delegates to the AMA are James Ahstrom Jr., MD, Downers Grove; George Beranek, MD, Chicago; Richard Bulger, MD, Hinsdale; Dr. Drueck; Alec Hood, MD, McLeansboro; Theodore Kanellakes, MD, Joliet; Dr. Orlowski; Nestor Ramirez, MD, Urbana; Marc Schlessinger, MD, Aurora; Neil Winston, MD, Chicago; and Sharyl Truty, a student at the Loyola University Stritch School of Medicine. ■

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Judicial fairness

PAGE 4

Medical records tell a story

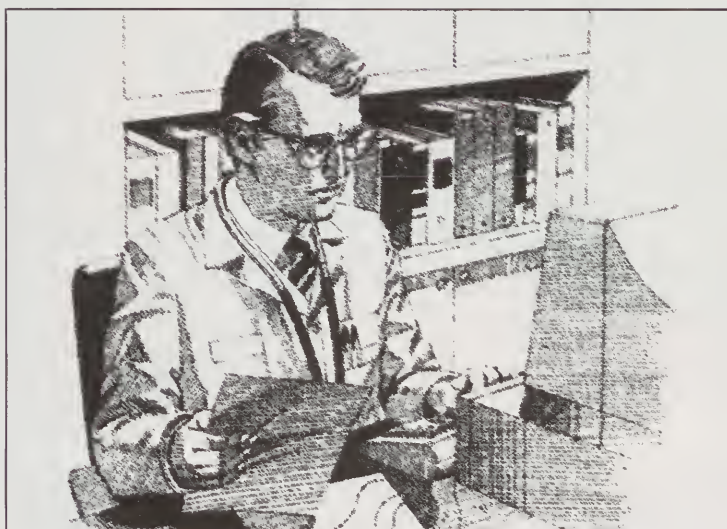
Following basic rules will ensure that documentation is factual, legible, properly updated and detailed. BY CHRIS PETRAKOS

Maintaining clear, accurate medical records is essential to providing quality patient care, but it has an extra benefit. It helps physicians with their defense if they're sued for malpractice. According to ISMIE data, the number of claims that close with indemnity payments is 17 percent for ISMIE claims in general but nearly 53 percent for claims involving record-keeping problems. But by following basic principles, doctors can prepare patient records that accurately reflect the treatment given.

Dorothy French, an attorney at Hinshaw and Culbertson in Lisle, said a fundamental rule is to write legibly in ink. "It's extremely embarrassing when physicians cannot even read their own writing in court. What physicians have to remember is that if there is a trial, their records are probably going to be enlarged and reviewed by the jury. Indecipherable documents are not going to be very persuasive to a jury."

Jim Christman, an attorney at Wildman, Harold, Allen and Dixon, said that entries should not only be written in ink but should under no circumstances be eradicated. If an error is made in the medical record, draw a single line through it. Larger portions can be corrected by drawing an X through the entire section. In either case, the word "error" should be written above the crossed-out material along with the date and the physician's initials. If important information was omitted, an addendum may be added to the record, but it should be clearly dated and initialed by the doctor.

The patient's name should appear on every page, Christman advised, and all diagnoses and recommended treatments should be entered. There is some debate over whether the doctor should chart negative findings. "Many doctors will tell you that they only chart positive findings and that you can infer from the



record that all the other things are negative. But an argument can be made that negative findings should be charted because it allows the subsequent treating physicians to see what their predecessor ruled out or discarded by way of medical judgment. The failure to chart negative findings can be a problem because there is no proof that the physician ever looked for a particular thing."

French recommended that physicians give preprinted forms to patients. "It's more efficient for patients to fill out their history and complaints, as well as the reason for the office visit," she said. "So many cases deal with the patient saying, 'I saw the doctor for X,' and the physician gets up and says, 'Well, she never complained about that to me,'" French explained. "But if you have the patient write down why he or she made the appointment with the doctor, those types of arguments are easily dismissed."

Both attorneys said telephone messages are a potential trouble spot. "I know it's hard, but all phone calls to and from the patient should be documented," Christman said. "I had a case recently where the patient claimed she had called the nursing staff. Eventually, she got phone records that showed she had made phone calls to the front desk precisely as she stated

in her deposition. The doctor was exonerated, but the corporation that employed these nurses had to make a settlement. So, it's imperative that doctors instruct their staff to make an

entry in the patient's record."

How the record is worded is as important as what is in it. It's better to write facts rather than conclusions, French said. "It's one thing to write that a patient has urinary retention. A better method would be to write, 'The patient last urinated at 8 a.m., and it is now 4 p.m.' From there, you can go on to say that the patient has urinary retention. By putting the facts first and then coming to a diagnosis, physicians are able to show how they came to their conclusions. That helps with continuity of care. Physicians who may come in at a later time will be better able to understand what the thought processes were."

Discharge instructions aren't always clearly spelled out in the medical records, Christman said. There should always be a discharge note and documentation that the doctor saw the patient immediately before discharge. "If you're discharging your patient from the office, it's important to write the instructions in the office record."

Instructions should be as specific as possible, French said, and the patient should sign two copies of the discharge document, one to keep and one to stay with the physician. "None of this is any good if patients don't sign it. Otherwise, they'll say they never got it."

The most important thing to remember is that the medical record is telling a story that requires all the pertinent details, Christman said. "The medical record is the doctor's friend, his or her ally. It's very difficult for a plaintiff to impeach a medical record; it is inherently credible because it was contemporaneous. It was written at a time when no one was thinking about a lawsuit or covering himself or herself or being defensive. That's why doing it the right way is important."

To help physicians learn more about medical records, ISMIE offers a booklet on documentation, record retention and access to records. Call the Risk Management Division at (312) 782-2749 or (800) 782-4767 to get a copy. ■

MALPRACTICE ROUNDUP

HMO held responsible for not disclosing incentives

The 8th U.S. District Circuit Court of Appeals ruled that under the Employee Retirement and Income Security Act, an HMO had a fiduciary duty to tell plan participants that it gave financial incentives to primary care physicians to curb their referrals to specialists, according to the March 24 issue of the National Law Journal.

In *Shea vs. Esenstein*, a patient told his family physician that he was experiencing chest pain, shortness of breath, muscle tingling and dizziness. The physician said a referral to a cardiologist was unnecessary, but the patient later died of heart failure. The plaintiff attorney told a district court that the patient's HMO provided financial incentives to reduce referrals to specialists and penalized physicians if they made too many referrals.

The district court disagreed, stating that ERISA doesn't require HMOs to disclose physician compensation arrangements because they are not material facts that affect enrollees' interests. But the circuit court held that such an incentive scheme is material information. It ruled that the patient had a right to know about financial incentives that affected his physician's judgment about referral and that failure to disclose those incentives breaches fiduciary duty.

Physician negligent for false positive drug test

A federal district court in New York state ruled that a worker who received a false positive reading on a drug test can sue the physician who performed the test for negligence, according to the March issue of *Medical Malpractice Law & Strategy*.

In *Santiago vs. Greyhound Lines Inc.*, the plaintiff said that when the test was done in the doctor's office, he was supposed to watch the sealing of the sample and initial the specimen. But the patient left the doctor's office, and an office employee ended up initialing for the patient. When the test came back positive, the patient was fired from his job.

The defending physician said he owed no duty to the plaintiff, but the court disagreed. The court's decision was supported by "significant social considerations," the newsletter reported.

Obstacles to Schedule II pain medications

The world of pain management is getting 'curiouser and curiouser,' but

BY CHRIS PETRA



Jane Marinsky

When Alice ventured into Wonderland, she had no idea where her trip would lead. The same might be said of prescribing higher-level medications that are governed by state law – only the possibilities include investigations. In Illinois, the distribution of Schedule II narcotics is regulated by the Triplicate Prescription Control Program, established in 1984 under the supervision of the Illinois Department of Alcohol and Substance Abuse. Sue Gorman, the program's regulatory supervisor, said that some physicians may think the program interferes in the physician-patient relationship and avoid using it for that reason.

Jim McGee, MD, chairman of the Illinois Board of Public Health, an advisory panel within the Illinois Department of Public Health, said the triplicate pro-

gram is a barrier to good pain management. "Primary care physicians feel they are subjected to a lot of scrutiny if they are writing pain medications too liberally. It's very common to see patients who are in advanced stages of life-threatening disease, and their physicians have been giving them combination drug products – such as Tylenol with codeine – that are less effective but do not require triplicate prescription forms."

Specialties are a consideration in investigations, according to DASA Deputy Director Ronald Vlasaty. By the nature of their specialty, oncologists, for example, prescribe significant amounts of powerful drugs, so the department rarely investigates them, he explained. On the other hand, DASA investigators might look further at physicians prescribing drugs beyond the norm for their specialties.

The types of records doctors must keep and the way

Schedule II drugs keep on out of reach

Documentation and recognition of drug-seeking behavior can help restore order.

BY WENDY ANDERSON

they must prescribe various drugs, including Schedule II medications, are governed by the Illinois Controlled Substances Act, Gorman said. DASA sells pads of 100 numbered triplicate forms for \$10 to record Schedule II prescriptions. Copies of each prescription are maintained by the physician, the pharmacist who fills the prescriptions and DASA. Pharmacists are responsible for sending the third copy to the state, and DASA compiles the data and creates computerized profiles. Gorman said that suspicious-looking profiles are passed along primarily to the Illinois Department of Professional Regulation, the U.S. Drug Enforcement Administration or the Illinois State Police.

Illinois' Medical Disciplinary Board is reviewing internal guidelines for monitoring the prescribing of higher-level medications, said board chairman Eloy Moscoso, MD. "We're trying to determine what is proper for us to make judgments on pain medications [prescribed] by physicians."

Some physicians have expressed concern that the field of suspicious activity is broad and that their peers have been subjected to needless investigations. Gorman said physicians could arouse suspicion by self-prescribing powerful drugs regularly, excessively prescribing drugs for family members or repeatedly prescribing such drugs as Dilaudid, which has a high street value and is likely the most commonly abused Schedule II drug.

"I have called up physicians to tell them about a patient who was not doing well and to ask if we could change their medication to something like Dilaudid," said Martha Twaddle, MD, medical director of the Illinois State Hospice Organization. "The first thing they will ask is, 'Is that a triplicate?' The hassle factor is very high, and when that happens, physicians are reluctant to use it."

Gorman said physicians should not feel forced to provide less than what their patients need. "The whole purpose of the triplicate program is to encourage appropriate prescribing. If it means that a patient is in severe pain and needs two or three kinds of pain medicine to manage it, then it should be done. And you're not going to run into any problems with our program if you're doing that."

Vlasaty said he understands that physicians may be concerned that the program impinges on the physician-patient relationship and raises confidentiality issues. But he added that since the triplicate program began, there has been "not one breach of confidentiality, no lawsuits, no complaints."

Program violations by physicians are rare, Vlasaty said. More common are "doctor-shopping" patients who use more than one doctor to obtain addictive pain medications. In those cases, physicians essentially become victims, according to Gorman and Vlasaty. One suburban Chicago physician told DASA about a patient who landed in a drug rehabilitation program after a pharmacist alerted him that the patient was getting the same Schedule II drug from a variety of physicians.

But doctor-shopping has decreased over the past few years as a direct result of the triplicate program,

Gorman said. Correspondingly, the number of doctors penalized for violations has also dropped. DASA data shows the department's production of investigative profiles has also decreased by more than 80 percent from fiscal year 1990 to fiscal year 1996.

Nevertheless, physicians should always document their prescribing carefully, since poor documentation is the main reason some physicians run into trouble with prescribing Schedule II drugs, said IDPR Chief Medical Coordinator Andrew Gorchynsky, MD. "When we [examine] the records, we must understand their rationale for these prescriptions."

Better education about prescribing Schedule II medications is needed, said Constance Bonbrest, MD, chairman of ISMS' Council on Mental Health and Addiction. DASA offers information to help physicians comply with the triplicate program and prescribe pain medication that is "responsible and appropriate. [This] is a step in the right direction for getting patients the kind of pain relief they need."

It's also imperative to learn to recognize drug-seeking behavior in patients, said Susan Link, IDPR staff attorney. "It's not unusual for people to come in and say things like, 'The dog ate my pills.' 'I dropped them down the sink.' 'I left them at my sister's house and I need more.' If you have somebody coming in to see you from 200 miles away and they've passed 20 doctors to get to you, that should send up a red flag."

In cases related to patients suffering from chronic pain, IDPR investigators look for proof that physicians have done their best to treat the illness, not just the symptoms, Link said. "A lot of times I'll see records, and the only thing the doctor will have written down is 'pain.' There is no diagnosis as to the probable cause of the pain. There is no documentation of referrals. It will just say 'back pain.' And that's how the doctor has been treating it for years."

Link said she once looked at the records of a physician who was prescribing "huge amounts" of Dilaudid to a patient on a weekly basis. She initially expected the physician's license to be revoked immediately. "The patient signed a release to let us see the medical records, and it turned out that he was in his early 30s and had a multitude of health problems, including 28 surgeries, Crohn's disease and a problem with his jaw that caused him considerable pain. They had tried Demerol injections to control his pain, but he was allergic. The only thing that worked was to give him 400 Dilaudid a week, because it took that much to get his pain to the level where he could function. And it was all completely documented. Case closed."

"We're not here to regulate them, but to prevent the misuse, abuse and diversion of Schedule II drugs," Gorman said. "In most cases, what physicians are doing is appropriate. And the rules they need to know to comply with the law are relatively simple."

To get copies of DASA's triplicate program information, write to Gorman at DASA, James R. Thompson Center, 100 W. Randolph St., Suite 5-600, Chicago, IL 60601. ■

*Primary care physicians
feel they are subjected
to a lot of scrutiny if
they are writing pain
medications too liberally.*

ISMS delegates seek changes in managed care procedures

RESOLUTIONS: Other issues include changes in RBRVS and itemized hospital bills. BY DAVE WIETHOP

[OAK BROOK] With the General Assembly's spring discussions about several managed care bills fresh in their minds, members of the ISMS House of Delegates approved resolutions that aim to change the way managed care organizations work with physicians. Nearly

half the resolutions discussed by Reference Committee B, which was charged with studying health care finance issues, dealt with third-party payers. The HOD and the reference committee met at the April Annual Meeting.

Delegates approved a resolution that

seeks legislation requiring managed care plans to disclose the incentives they offer physicians who limit care or diagnostic tests. The resolution also calls for plans to answer patients' queries about how their physicians are paid and to permit physicians to tell patients about all available treatments, including those not covered by the plans. In addition, the resolution and related legislation would protect physicians from plans' retaliation for appeals to plan decisions.

Another resolution approved by delegates directs the Society to urge state agencies to require managed care plans to process physician applications in three

months and penalize plans for noncompliance. Delegates also passed a resolution directing ISMS to study the implications of physician deselection from managed care plans.

ISMS will support or develop a bill to make it unlawful for all Illinois third-party payers to require physicians to participate in their entire product line as a basis for plan eligibility, according to another HOD-approved resolution. In addition, delegates passed a resolution seeking state legislation to eliminate gag rules.

The HOD also approved working toward a requirement that only licensed physicians could deny tests or procedures on behalf of third-party payers, since those decisions could constitute the practice of medicine.

The delegates referred a "managed care adequacy model" to the ISMS Board of Trustees for further study. The resolution asks for legislation that would require managed care plans to give 60 days' notice before canceling any contract, find appropriate expertise within or outside their networks to handle all covered benefits at no additional cost, document their utilization review with the Illinois Department of Insurance and allow enrollees to appeal coverage decisions. The resolution also calls for banning managed care plans from billing enrollees for fees other than coinsurance, deductibles and copayments.

With members calling the RBRVS system "imperfect" and "grossly inadequate," the delegates approved a resolution urging the AMA to work with the Health Care Finance Administration to develop a valid resource-based practice cost payment methodology that is fair to all medical disciplines. Other resolutions, which this substitute resolution replaced, asked that the AMA condemn HCFA's "attempts to destroy the practice of medicine," especially specialty care, and to resist "with extreme vigor" the use of RBRVS to fund specialty care. Changes in RBRVS should include increasing the work value units for surgeons and specialists to "accommodate the gross deficiencies" seen within the system, according to the original resolutions.

The delegates referred to the ISMS trustees a proposal requesting that the AMA seek equal Medicare reimbursements for physician services whether they are provided in inpatient, outpatient or ambulatory surgical center settings.

The delegates also agreed to work toward expanding uninsured children's access to health care covered by third-party payers and to support the Illinois Health Facilities Planning Board's allowing certificates of need for single-specialty ambulatory surgical treatment facilities.

With one physician calling it "Medicare for pediatricians," the HOD adopted a resolution asking the AMA to work against the Clinton Administration's proposed "KiddieCare" medical program. Some delegates said they opposed entitlement programs that would expose the U.S. health care system to further governmental control.

One approved resolution asks for ISMS to look into legislation requiring hospitals to provide itemized hospital bills when patients ask for them. Although the reference committee agreed that many hospitals now provide such bills, one physician said patients may not understand that the bills reflect amortized costs — not actual costs — of the services and supplies provided. ■

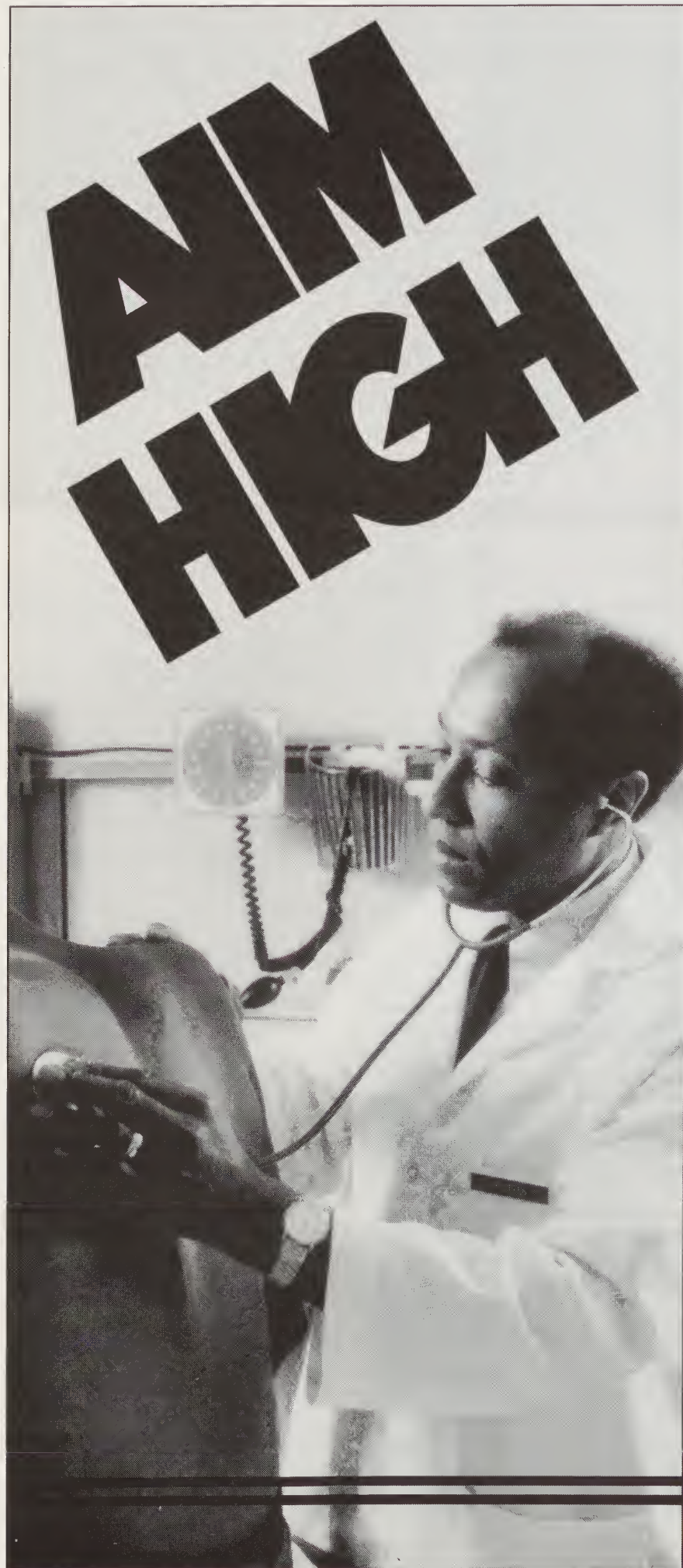
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IDPA seeks bids

(Continued from page 1)

to get more managed care opportunities available to Medicaid clients," Hovanec said. "We have been waiting on MediPlan Plus for some years, and since there's some uncertainty as to the start date of that program, we thought now was the time."

MediPlan Plus, the state's proposed mandatory managed care program, was designed to improve health care delivery to the state's Medicaid recipients and to control costs through managed care. The U.S. Health Care Financing Administration granted Illinois a waiver in July 1996 allowing IDPA to assign managed care providers to those recipients who failed to select one and to lock enrollees into their chosen or assigned provider for one year. IDPA is still awaiting approval from HCFA on other documentation necessary to implement the program.

The current bidding process, however, has nothing to do with the implementation of MediPlan Plus, Hovanec said. Any contracts granted during this bidding process will be phased out as

MediPlan Plus is implemented, probably within the next two years, according to the state's bidding documents. Regardless of the status of MediPlan Plus, the contracts will automatically expire on Sept. 30, 1999.

Bids are due June 18, and all the contracts should be in place by Oct. 1, at which time enrollees can begin receiving services, Hovanec said. The state expects to have at least 12 HMOs in Cook County and probably 10 serving Downstate recipients.

These contracts beef up quality assurance and monitoring procedures the HMOs must follow, Hovanec said. For

example, penalties have been increased for marketing abuses.

Hovanec added that "providers will still be allowed to do fee-for-service medicine if they want." Physicians may tell their patients who don't want to join an HMO that they don't have to join, he added.

HMOs that violate these provisions may be fined as much as 20 percent of the monthly capitation.

HMOs will be required to establish procedures to monitor the health care services furnished, stress health outcomes, establish and monitor access standards, provide physicians with data

related to performance and outcomes, and institute any needed changes, according to the bidding documents. A written quality assurance plan also must be submitted to IDPA.

For the most part, the same health care services will be provided under these contracts as under the existing HMO contracts, Hovanec said. One change, however, is the use of the "prudent layperson" definition of emergency services, which would require HMOs to pay for patients who visit the emergency room because they reasonably believe their condition would result in a serious health impairment. ■

ISMIE maintains base

(Continued from page 1)

pay to cover those estimated losses.

"Of course, it would be great if everybody was the same," said an ISMIE analyst. "If you don't have any accidents with your auto, you don't want to pay the same rate as the guy next door with three teen-age sons who are driving over everybody's lawn and wreaking havoc in the neighborhood." ISMIE examines data annually to compare the insurance risk of various specialties and adjusts rates accordingly.

When calculating rates, analysts study severity, or how much money was paid out per claim, and frequency, or how many suits are filed. They then try to identify trends. "In some instances, [the reduced rates are caused by] decreased severity, and in others it is decreased frequency," the analyst said. ISMIE watches changes over a three-year period before considering fluctuations to be a trend.

"Because ISMIE is committed to vigorously fighting nonmeritorious lawsuits, the company can hold base rates and bring reduced rates to more than 2,200 physicians," Dr. Jensen said. "Last year, we took 134 cases to trial and won 86 percent of them, both of which are records. We have also held the amount paid per claim flat since the 1995 policy year. And for two years, we've held the base premium level despite increased inflation."

When calculating rates, ISMIE analysts also take into account regional differences. Some areas, like Cook County, don't have as favorable a judicial climate for medical malpractice cases as other areas do, the analyst said. After watching favorable trends for three years, ISMIE also dropped the premium rates by 10 percent for 123 physicians practicing in McHenry County.

In addition to changes in ISMIE's rates, another 7,000 policyholders will benefit from ISMIE's loss-free discount program. Physicians who have experienced three or more consecutive years without losses are awarded premium discounts ranging from 3 percent to 10 percent. ■

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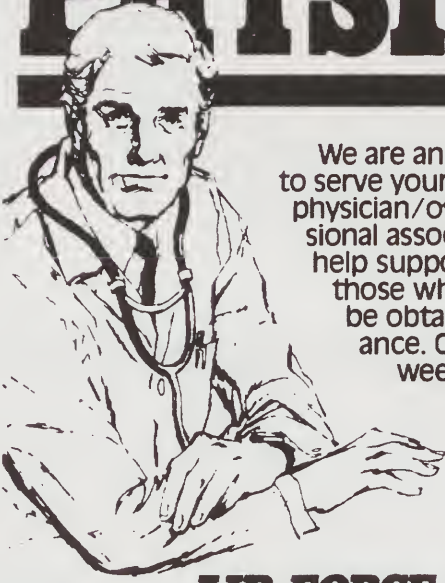
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This information, published as space permits, is reprinted from the Illinois Department of Professional Regulation's monthly disciplinary report. IDPR is solely responsible for its content.

December 1996

Kwan Bo Jin, Normal – physician and surgeon license reprimanded and controlled substance license placed on probation for one year for allegedly failing to keep accurate records of prescriptions and overprescribing Ritalin to a patient.

Patricia G. Jones, Chicago – physician and surgeon license and controlled substance license indefinitely suspended for failing to comply with a Medical Disciplinary Board order that compelled her to submit to mental and physical examinations.

Wynne Lenci, a.k.a. Wynne Superson, Chicago – physician and surgeon license and controlled substance license revoked for allegedly failing to comply with the terms and conditions of a previously ordered probation, allegedly submitting billings to insurance companies for services not rendered for two persons and being found guilty of a felony after being charged with attempting to carry out an interstate murder-for-hire with the intended victim being an ex-husband.

Olivo V. Leopando, Ottawa – physician and surgeon license reprimanded after

stating on an application for a controlled substance license that he had never been disciplined when his license had been disciplined.

Ismail Hakki Oztekin, Mount Prospect – physician and surgeon license reprimanded for neglecting to inform a patient about a potential problem with a tubal ligation that may have resulted in pregnancy.

Natwarlal Ruparell, Sterling – controlled substance license restored to indefinite probation.

Felix Vasquez-Ruiz, a.k.a. Felix Vasquez, Chicago – physician and surgeon license placed on indefinite probation due to unpaid income tax liability owed the Illinois Department of Revenue.

Thomas Bruce Vest, Godfrey – physician and surgeon license revoked after being convicted of a felony, failing to report his exclusion from the Medicare program and committing gross negligence in the treatment of one patient.

Salvador A. Vivit, Des Plaines – physician and surgeon license indefinitely suspended for failing to comply with the terms and conditions of a previously ordered probation.

January 1997

Chaovane Aroonsakul, Naperville – physician and surgeon license indefinite-

ly suspended and fined \$5,000 after marketing herself as discovering an effective treatment for Alzheimer's disease.

Charles William Cooper, Frankfort – physician and surgeon license issued and placed on probation until 2005 due to a chemical dependency history and after being disciplined in the state of Indiana.

Raul J. Puertollano, Decatur – physician and surgeon license indefinitely suspended due to unpaid income tax liability owed the Illinois Department of Revenue.

M. Kim Rodine, Peoria – physician and surgeon license placed on indefinite probation and controlled substance license indefinitely suspended after habitually using and self-prescribing Vicodin, a controlled substance.

Charles Sutherland, Carthage – physician and surgeon license indefinitely suspended for failing to comply with the terms and conditions of a previously ordered probation by ingesting Fiorinal, a controlled substance, which had not been prescribed by or approved by his treating physician.

Thomas E. Wood, Centralia – physician and surgeon license placed on indefinite probation and controlled substance license indefinitely suspended after allegedly prescribing controlled substances for persons other than patients.

February 1997

Charles P. Buckley, Fairfield, Iowa – physician and surgeon license suspended for four months followed by probation for three years and controlled substance license placed on probation for three years concurrent with probation imposed on physician and surgeon license after being disciplined in the state of Iowa.

Elaine Regina Ferguson, Chicago – physician and surgeon license reprimanded after treating a patient with AIDS with a drug named Immunex, which was not approved for this use by the Federal Drug Administration.

David R. Lewis, Decatur – physician and surgeon license placed on probation for three years after allegedly failed to implement proper patient care measures for his spouse, who was afflicted with multiple sclerosis.

David Massman, McHenry – controlled substance license restored to indefinite probation.

Srinivasan Ravindran, Lemont – physician and surgeon license and controlled substance license placed on probation for two years after allegedly rendering a urine screen positive for morphine pursuant to an employee drug test.

Alexander Sagal, Niles – physician and surgeon license reprimanded and fined \$5,000 after allegedly aiding and abetting the unlicensed practice of medicine.

Isaias D. Sunga, Tinley Park – physician and surgeon license and controlled substance license placed on probation for two years after prescribing Phentermine diet pills for long periods of time and failing to have authorized personnel in

attendance during female examinations at his office.

March 1997

Roselle DeCarlo, Hoffman Estates – physician and surgeon license and controlled substance license summarily suspended pending proceedings before the Medical Disciplinary Board due to alleged mental illness.

Jerome Frankel, Lincolnwood – physician and surgeon license and controlled substance license placed on indefinite probation due to diverting controlled substances for his own use.

Cesar Giannotti, Aurora – physician and surgeon license placed on indefinite probation for failing to comply with a mandatory review agreement with a hospital, failing to adequately chart two patient records and leaving a mark on a 6-year-old patient's face while trying to stop the patient, who was having blood drawn, from moving.

Merlin Kelsick, Chicago – physician and surgeon license reprimanded and fined \$500 for failure to report two adverse settlements to the department arising from professional liability claims and failure to furnish information requested by the department in connection with one of these claims.

Arnold E. Lee, Canton – physician and surgeon license and controlled substance license placed on probation for three years for prescribing controlled substances for other than therapeutic purposes, failing to provide effective controls in the inventory and storage of controlled substances and failing to report to the department his employment discharges from Henry Hill Correctional Center and Cottage Hospital.

Gil Rich, Clarendon Hills – physician and surgeon license reprimanded for failure to report his involuntary termination from the Medical Assistance Program by the Department of Public Aid.

Ched C. Vugrincic, South Elgin – physician and surgeon license revoked for failing to comply with the terms and conditions of a previously ordered probation.



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for her "patience, kindness and support during a very trying time," Paula Gentry received the ISMS Employee Recognition Award in April. Gentry is a senior professional liability analyst in the Rockford claims office.

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Illinois Nursing Act

(Continued from page 1)

tice detailed in those bills.

The measures permit APRNs to use "advanced diagnostic skills, the results of diagnostic tests and procedures ordered by APRNs or others and independent judgment to initiate and coordinate the care of patients." The scope of practice defined in the bills also includes "prescribing, dispensing and administering drugs" without indicating any limits on APRNs' prescriptive authority.

The ISMS House of Delegates has several policies regarding APRNs. The House agreed in 1994 that even if physicians do not personally deliver every professional service to patients, they are still responsible for managing patients' health care. The Society supports the use of properly trained nurse practitioners as long as supervision by a physician is guaranteed, the physician retains responsibility for the medical care given by the nurse practitioner, the physician is responsible for no more than two nurse practitioners and the nurse practitioners are in the same medical service area as the physician. Policy also states that among the key areas separating APRNs from physicians are the level of training that each profession completes and the impact of that training in guaranteeing quality care to patients.

"Doing a history and physical examination and making a diagnosis — that's what we define as the practice of medicine," Dr. Cummings explained. "Nurse practitioners do perform those, but we don't believe it ought to be done independently. They're talking about making a diagnosis and initiating treatment. Those are things that we believe are the purview of medicine."

Illinois Society of Internal Medicine President Craig Backs, MD, explained the differences between physician and APRN training. Physicians have to complete two years of postgraduate training before they can be licensed, he said. "Before we can become board-certified, we have to complete a residency program that includes intensive clinical experience with a wide variety of patients. To the best of my knowledge, no such equivalent training exists for advanced practice nurses."

Legislative observers don't expect any APRN measures to pass the General Assembly this spring, since negotiation is still in progress. "We plan to meet with representatives from the Medical Society throughout the summer to see if we can't come together to work on an agreed-upon piece of legislation," said Stephen Flaherty, governmental relations chairman for the Illinois Association of Nurse Anesthetists.

ISMS is developing a task force with representatives from such groups as anesthesiologists and family physicians to get their input on needs and potential problems, said M. LeRoy Sprang, MD, an Evanston Ob/Gyn and chairman of ISMS' Board of Trustees. "We want to work with nurses and traditionally have worked well with them. We certainly see a place for advanced practice nurses, and obviously some of the details need to be worked out."

One area of disagreement is the nurses' contention that the law should reflect everyday occurrences. "We are trying to codify what's going on right now. Practice has far exceeded regulations," said

Alison Watkins, RN, who is an APRN and chairman of the Illinois Nurses Association's Council of Nurse Practitioners. "Right now, when I see a patient I make a diagnosis, and then I prescribe a medication. I'm not signing my name to that prescription. I'm signing a physician's name and then [putting a slash] and using my name."

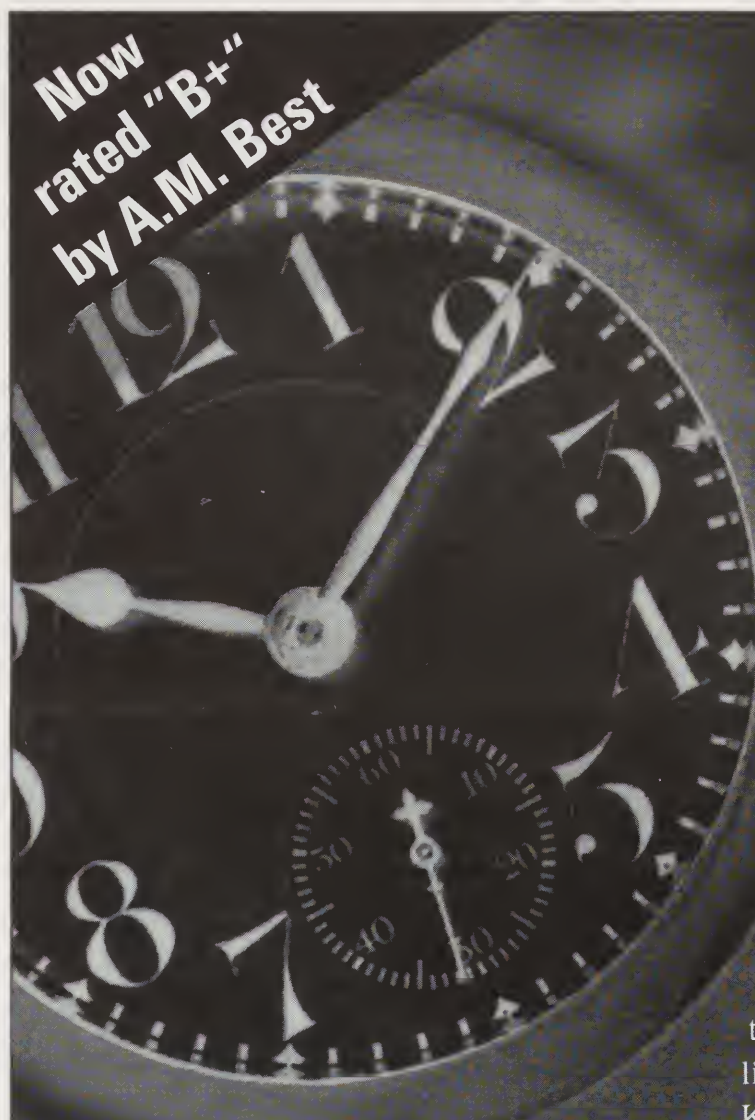
Rodney Osborn, MD, ISMS Fourth District trustee and past president of the Illinois Society of Anesthesiologists, responded to the nurses' position. "What the nurses have said is, 'We're doing this independently. Why can't we just pick the drug and write the prescription?' And

we've said, 'No, you're practicing under the direction of the physician.' It's his or her decision and his or her expertise and education that developed that protocol that helped [the nurse] provide care for the patient."

APRNs also say that Illinois law is out of step with legislation in other states. For instance, Flaherty said Illinois is one of only two states that do not recognize APRNs and the only state that doesn't provide prescriptive authority for at least one of the four groups of advanced practice nurses. "Illinois is, to put it very kindly, not on the cutting edge," Watkins said.

According to the American Nurses Association, however, prescriptive authority for the four groups of APRNs varies from state to state.

Dr. Backs said that managed care may also become more of an issue in APRNs' scope of practice. "We have to be aware that managed care organizations might view more favorably nurses being able to practice independently because they feel they can employ or contract with nurse practitioners for a lower cost than for physicians. We have to be wary of the outcomes that could have for patients who are enrolled and cared for through managed care plans."



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LEGISLATIVE SCORECARD (PAGE 7)

IDPR audit, rebuttal released

PAGE 2

Illinois Medicine

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INSIDE

Rules
of thumb
for record
retention



PAGE 6

DEPARTMENTS

**Malpractice
Roundup.....6**

Classifieds9

Supreme Court hears oral arguments in challenge to 1995 tort reform law

PRELIMINARIES: Court allows only opponents of law to file amici. BY JANE ZENTMYER

[SPRINGFIELD] The Illinois Supreme Court formally began deliberations on the constitutionality of the 1995 tort reform law on May 21 when justices heard oral arguments in *Best vs. Taylor Machine Works* – a product liability case that originated Downstate.

The oral arguments lasted just over one hour, with both sides arguing the pros and cons of tort reform provisions including ISMS' top priority – the \$500,000 noneconomic damages cap that is indexed to inflation. Well-known Harvard law professor Laurence Tribe argued for the plaintiffs that the cap is unfair and unconstitu-

tional. The defendants argued that the reforms were passed by the Legislature, the appropriate policy-making body for the state of Illinois.

"As far as the oral arguments, the logic and strength of the arguments on our side of the issue – as expressed by the attorney general's office and by one of the attorneys for the defendants – were very positive," said Edward Murnane, president of the Illinois Civil Justice League, a coalition of organizations, including ISMS, that joined forces to support tort reform. "If the court makes its decision based on the Illinois Constitution and the separation of pow-

ers, there is no doubt that the court should uphold the civil justice reform amendments."

The justices will begin deliberating the issues but have no deadline for issuing their ruling. "We just have to wait and see," Murnane said. "The court's unwillingness to consider all

sides of the issue – particularly in such an important case as this, which the court itself has put on a fast track – is unheard of."

Murnane was referring to the Supreme Court's preliminary processes in the case. The court opted not to accept amicus
(Continued on page 11)

Session ends with managed care pending

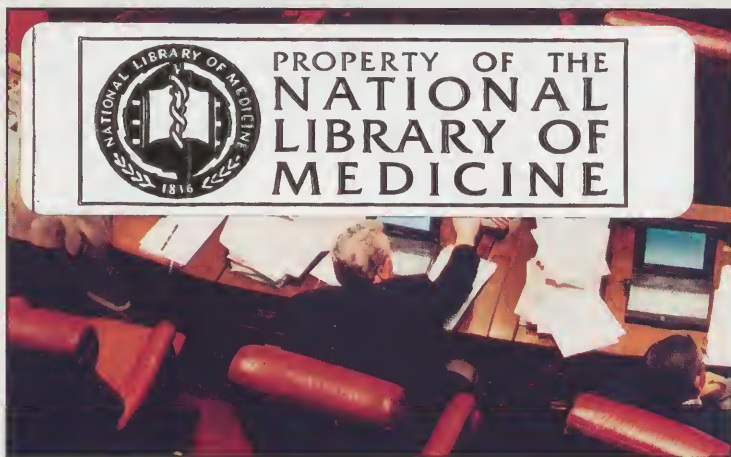
OVERVIEW: Although comprehensive legislation has yet to pass the General Assembly, hearings will continue. BY JANE ZENTMYER

[SPRINGFIELD] Although the Illinois General Assembly adjourned its spring 1997 session without sending a comprehensive managed care reform bill to the governor, the session could be remembered as the first time any such legislation passed the House of Representatives.

The single, comprehensive bill to advance from either chamber was the ISMS-supported H.B. 626. Substantial portions of the legislation should look familiar to ISMS members.

"Many key elements of the [ISMS-developed] Managed Care Patient Rights Act were incorporated into H.B. 626," said Rep. Jeffrey Schoenberg (D-Wilmette), a sponsor of H.B. 626 and the lead House sponsor of MCPRA. After being refined for nearly a year before the spring 1997 session, MCPRA was reintroduced into the Legislature in February but failed to advance.

Instead of choosing a pending bill like MCPRA to advance, the House Health Care Availability and Access Committee decided to hear testimony from supporters and oppo-



SENATORS CAST THEIR VOTES as the spring session winds to a close.

nents of reform before crafting a compromise bill using New York legislation as a model, said Rep. Mary Flowers (D-Chicago), committee chairman and lead sponsor of H.B. 626. In the final version, representatives addressed the divergent interests of several groups involved in the managed care debate. Flowers said, "We talked to many organizations and different groups trying to put forth the best bill possible."

The bill would require plans

to disclose to consumers such information as covered benefits and the appeals process. A board – whose voting members would include network physicians, providers and enrollees – would review all aspects of the managed care plan. The bill would ban gag rules and prevent gag practices by prohibiting plans from terminating or refusing to renew physicians' contracts because doctors filed a complaint against the plan,
(Continued on page 11)

Lawmakers OK \$35 billion budget

After ending its discussion of education reform, the Illinois General Assembly put its stamp of approval on an approximate \$35 billion budget for fiscal year 1998 on June 1. The approved budget holds physician Medicaid reimbursement steady and the bill payment cycle at 20 days or less.

"It's clear there's enough money in the physician line to pay people reasonably promptly," said John Schneider, MD, chairman of ISMS' Third Party Payment Processes Committee.

The total 1998 appropriation for the Illinois Department of Public Aid is \$3.7 billion, according to an ISMS analyst. "We're pleased with the budget because it allows the Medicaid program to continue to maintain quick reimbursement to Medicaid providers," said Dean Schott, IDPA spokesperson.

Changes from the governor's proposal in March to the final version that passed in June reflect a delay in implementing MediPlan Plus, a reform program that seeks to rein in Medicaid costs by moving more than 1 million recipients to managed care.

If the program had been implemented, IDPA planned to shift funds from the budget line that reflects payments for fee-for-service physician bills to the line that reflects payments for managed care services. As a result of the delay, the managed care budget line reflects a \$90.9 million decrease. The physician line for services has been increased by \$12.5 million, and the hospital lines increased by \$55.6 million to accommodate an expected increase in the fee-for-service bills as a result of the lower-than-expected enrollment in managed care organizations.

Changes between fiscal years 1997 and 1998 include a 7.2 percent increase in the prescription drug line, a 31.2 percent increase in the home health care line, a 1.7 decrease in long-term care and a 9.3 percent increase in Medicare Part B premiums.

The 1998 budget also reflects the state's work at reducing the payment cycle for physicians. The cycle is expected to be 20 days, a considerable improvement from the 100-day cycle in fiscal year 1994. When fiscal year 1998 ends, the state expects to have \$280 million bills on hand, only a slight increase from fiscal 1997.

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IDPR audit, rebuttal released

REPORT: Auditor general makes 16 recommendations on processing of complaints against physicians. BY JANE ZENTMYER

[SPRINGFIELD] On May 28, Auditor General William Holland released a report examining the effectiveness of the Illinois Department of Professional Regulation in investigating complaints against physicians licensed to practice medicine in Illinois. The report included a detailed rebuttal from IDPR.

"In our review of cases from fiscal years 1995 and 1996, we found instances

in which the department lacked adequate management controls in its investigatory, disciplinary and probationary processes," wrote Holland. In 1995 and 1996, the department received 3,661 complaints total and disciplined 236 physicians. The case review is based on examination of two samples totaling 695 cases.

The auditor general questioned the adequacy of 35 percent of the closed

cases. The report said that of the sample cases analyzed, 17 percent were closed without investigation; 13 percent appeared to have inadequate investigations; 4 percent involved disciplinary action that appeared questionable; and two case files were missing.

The report also questioned IDPR's timeliness stating that of the sample, 14 percent of the investigations were completed within the department's 90-day time limit. Delays of at least three months during which there was no substantive activity occurred in 23 percent of the cases that were investigated and in 28 percent of the cases prosecuted. The auditor

general also wrote that cases resulting in physician discipline took at least two years to finish.

The report recommended 16 actions including developing criteria for when to obtain medical records, helping medical coordinators reduce backlogs and improve timeliness, and creating guidelines for decision-making about disciplinary actions. The department didn't concur with eight of the recommendations, according to the report.

IDPR Director Nikki Zollar wrote a rebuttal to the auditor general's findings, stating, "The department objects to the content, tone and methodology underlying the auditors' report."

Zollar cited a case in the audit in which the department was criticized for closing and failing to investigate a complaint alleging that a physician had done unnecessary surgery. Because the department already had similar complaints about that physician, the auditors concluded that investigators should have probed more deeply. Zollar wrote, however, that the criticism was unjustified.

"A dog bit a person. The bite victim had surgery to repair the wound caused by the bite. The subject of the report performed the surgery, the quality of which was never questioned," Zollar wrote. "The victim, however, sued the dog owner; in an apparent effort to limit his expenses, the dog owner sued the doctor, alleging that the surgery was unnecessary. Ultimately, this ridiculous series of legal posturing ended with a nuisance settlement of \$10,000." The physician's license was later revoked for other transgressions, Zollar noted.

Criticism also fell on the department's handling of mandatory reports. But IDPR argued that the auditor general used the "tacit, flawed assumption" that a mandatory report automatically signifies a violation of the Medical Practice Act. "For two reasons, this assumption is wrong," Zollar wrote. "First, civil malpractice actions require only that the plaintiff prove simple negligence by a preponderance of the evidence. The act, however, requires proof of gross negligence by clear and convincing evidence. An allegation of negligence in a civil action, therefore, is far easier to prove than a violation of the act." In addition, many insurance companies settle for reasons other than the facts of the case.

IDPR concurred with the auditor general that the department should ensure that its computer system supports the quality and timeliness of the enforcement process and require employees to report potential conflict of interests. Some recommendations, such as installation of a new computer system, have already begun to be implemented, according to IDPR.

Gov. Jim Edgar said he will listen to any recommendations his staff makes about the audits, according to a spokesperson.

ISMS President Jane Jackman, MD, said, "Doctors are confident that the Department of Professional Regulation does its job actively, thoroughly and effectively. It would be misleading and counterproductive to attempt to use this report to generate alarmism about the quality of medical care provided to Illinois patients. ISMS doctors will continue to review the audit report and will cooperate in any way possible to assist the department in upholding the high quality of health care that Illinois patients receive every day."

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High court lowers burden of proof to take med mal cases to trial

LIABILITY: Ruling may cause physicians to practice more defensive medicine. BY JANE ZENTMYER

[SPRINGFIELD] After 10 years of debate and conflicting decisions from appellate courts, the Illinois Supreme Court issued a ruling on April 17 in *Holton vs. Memorial Hospital* upholding the lost-chance doctrine — a legal standard that lowers the burden of proof that plaintiffs must meet to take medical malpractice cases to a jury.

"The law up to this point has been that in order to stake a kind of a claim that could get to a jury for consideration, the defendant had to be the proximate cause — in other words, at least 50 percent of the cause of a patient's condition or injury," said ISMS General Counsel Saul Morse.

The lost-chance doctrine, however, requires the plaintiff to prove only that the defendant is responsible for any part of the condition or injury, even if it's less than 50 percent, Morse explained. Defendants can then be held liable for their portion of that lost opportunity to cure a disease or to make a full recovery.

Morse gave an example of how the doctrine might be applied. A patient is diagnosed with breast cancer six months after the disease was evident from a mammogram. If the plaintiff can argue that the six-month delay in informing her about the disease reduced her chances of survival by 20 percent, the physician can be held 20 percent liable for failing to inform the patient sooner. Under the previous standard, a judge could have dismissed the case before trial.

"There is nothing novel about requiring health care professionals to compensate patients who are negligently injured while in their care," argued Justice Mary Ann McMorrow in the court's written majority opinion. "To the extent a plaintiff's chance of recovery or survival is lessened by the malpractice, he or she should be able to present evidence to a jury that the defendant's malpractice, to a reasonable degree of medical certainty, proximately caused the increased harm or lost chance of recovery."

This ruling most likely will result in more medical malpractice cases going before a jury, Morse said. It may also encourage physicians to practice more defensive medicine to minimize their liability risks. "If you have a situation in which some medical procedure or treatment might give a 5 or 10 percent chance of recovery or success, physicians have to be aware that if they don't try that, there is now a great chance of both

a suit — and a successful suit — because of this doctrine."

In his dissent, Justice James Heiple wrote that the doctrine could apply equally to other professionals. "If a disgruntled litigant loses a case that he probably would not have won but is able to

prove that his lawyer negligently reduced his chance of winning by some degree, no matter how small, the litigant would be able to pursue a cause of action for malpractice against his attorney under the lost-chance doctrine," he wrote. "Only the client with no chance of success would be foreclosed from some recovery under the lost-chance doctrine."

Heiple added, "I also fear that the majority's opinion is just one more step along the road to making medical professionals the insurers of their patients, rendering health care providers liable without regard to whether their negligence caused injury to the plaintiff." ■

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EDITORIAL

The end of session may be only the beginning

This issue of Illinois Medicine highlights the spring legislative session, especially ISMS' accomplishments. The volume alone was impressive; about 4,000 bills were introduced with nearly 20 percent related to health care. When the session ended on June 1, the General Assembly had passed many bills developed from the Society's positions and policies and defeated many of those we opposed. But our victories don't always end when the session does. Often we have to keep working to maintain them.

When the 1995 tort reform law was signed by the governor, we knew the plaintiff bar would try to nullify as many of the reforms as it could. This session, ISMS actively opposed and state legislators defeated three bills that aimed to undermine our progress. H.B. 61 would have repealed the requirement that physicians who sign affidavits of merit must identify themselves. Another measure, H.B. 538, would have allowed sealed court records of settled lawsuits to be opened. And H.B. 628 would have permitted interest on lawsuit judgments to begin accruing when an accident or negligent event occurred instead of when the judgment was rendered.

A study last year reported that certain tort reforms reduce pressure for physicians to practice defensive medicine and decrease medical expenditures without compromising health care outcomes.

Two of the specific reforms listed were the elimination of prejudgment interest on awards and caps on damages in medical malpractice cases. The study, conducted by an economist and a physician at Stanford University and the National Bureau of Economic Research, concluded that certain tort reforms "lead to reductions of 5 percent to 9 percent in medical expenditures without substantial effects on mortality or medical complications."

Another study concluded that payments to plaintiffs in medical malpractice cases were based more on the severity of patients' disabilities than on adverse events caused by negligence, according to the Dec. 26, 1996, issue of the New England Journal of Medicine. Researchers cited a case in which a neurologic injury followed a vascular procedure that was performed according to the standard of care. Even though the suit didn't involve negligence, a large payment was made to the plaintiff.

At the state level, the Illinois Supreme Court heard oral arguments on May 21 in *Best vs. Taylor Machine Works*, the case the court will use to determine the constitutionality of the 1995 law. Unfortunately, amicus briefs were accepted only from supporters of the plaintiff, so both sides weren't heard.

ISMS will keep pushing to win legislative victories in areas like tort reform and managed care reform and to hold on to our gains.

PRESIDENT'S LETTER

Why we should credential ourselves

Jane L. Jackman, MD



Patients are now checking up on doctors' qualifications and malpractice histories in the state of Massachusetts. The Florida Legislature passed a similar law in May, which, if approved by the governor, will provide profiles of the states' 43,000 doctors via telephone and the Internet. Similar legislation was introduced in eight other states this year, including Illinois. H.B. 73, the physician profiling bill, was defeated 85-25 in the Illinois House, but don't think it won't be back.

The Illinois bill was championed by "consumer groups" that are in part funded by plaintiff attorneys who say there is a direct correlation between a doctor's malpractice record and the quality of patient care. Of course, those of us who have been sued by patients realize that doctors, especially those in certain specialties, get sued rather frequently. Recent studies show that the likelihood of being on the receiving end of a lawsuit is more related to adverse outcomes and communication skills than to malpractice. Malpractice records can be very confusing, since often the best doctors are at highest risk because they care for the sickest patients.

Be that as it may, the experience in Massachusetts is that the public is very interested in checking up on their doctors, with 200 people a day calling the toll-free line. Public opinion surveys show that the public wants to have more information available to them about our profession. Maybe we should be looking at what type of information should be available to patients.

The AMA is proceeding with a program to do just that. AMAP, the American Medical Accreditation Program, is a centralized, voluntary accreditation program for individual doctors. Those who choose to participate will be rated on their education, licensing,

ethics, the way they practice medicine and their patients' outcomes. Details of the accreditation process will not be released to the public, but the AMA will publicize a list of doctors who earn the "gold star" of AMAP accreditation.

Of course, HMOs currently credential us, but most of this is duplicative and time-consuming, and we get very little feedback from them. By using a standardized program, the AMA plans to eliminate much of this individual credentialing, thereby reducing some of the hassle factor in medicine. We will also be able to use the information to do quality improvement in our practices.

Most patients currently seem to choose their doctors the same way they choose their dentists, attorneys and garage mechanics – by word of mouth. AMAP should help patients be reassured about the quality of new doctors. However, qualities such as compassion, kindness, the ability to really listen to patients' concerns – all of which are highly valued in us by patients – will probably continue to elude measurement. I urge all of you to consider participating in AMAP when it becomes available in Illinois. If we don't credential ourselves, we may find outside agencies doing it for us, as in Massachusetts.

I urge all of you to consider participating in AMAP when it becomes available in Illinois. If we don't credential ourselves, we may find outside agencies doing it for us, as in Massachusetts.

ISMS' actions reflected in range of bills

During the spring legislative session, ISMS focused primarily on managed care reform and the measure the Society developed – the Managed Care Patient Rights Act. But legislators also acted on other bills that stemmed from ISMS' policies and positions or that ISMS opposed.

ISMS opposed H.B. 73, for example, and called on member physicians to contact their state legislators and voice their opposition. In April, the House voted 85-25 to defeat the bill, which would have created a new program to offer physician profiles to the public via a toll-free telephone number. Sponsored by Rep. Janice Schakowsky (D-Evanston), the bill proposed profiles that would have included data about medical malpractice lawsuits without providing a context for that information. The bill failed to propose funding to cover its estimated \$8 million cost.

Legislators passed several practice acts for various allied health professional groups, including physician assistants and nurses. ISMS supported two identical bills, H.B. 557 and S.B. 372, which update the Physician Assistant Practice Act by allowing physicians to supervise two physician assistants instead of one and giving the assistants limited authority to prescribe Schedule III, IV and V controlled substances in accordance with written guidelines from IDPR. Both bills are awaiting Gov. Jim Edgar's consideration. Sponsors included Rep. Skip Saviano (R-River Grove) and Sens. J. Bradley Burzynski (R-Sycamore) and Louis Viverito (D-Burbank).

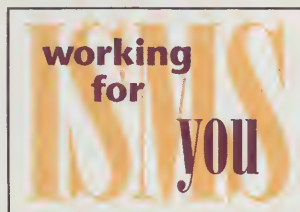
Also on the governor's desk are bills that extend other allied professionals' practice acts. Those in accordance with ISMS' policies and positions are the Clinical Social Work and Social Work Practice Act, the Marriage and Family Therapy Licensing Act, the Occupational Therapy Act, the Pharmacy Practice Act, the Podiatric Practice Act and the Speech-Language Pathology and Audiology Practice Act.

H.B. 1076 will extend the Illinois Nursing Act for another 10 years if signed by the governor, but the measure doesn't define advanced practice registered nurses or their scope of practice. Sponsors were Rep. Carol Ronen (D-Chicago) and Sen. Robert Madigan (R-Lincoln). ISMS took no position on the measure, but the Society is developing a task force with representatives from various physician specialties to discuss the APRN issue this summer.

ISMS developed H.B. 408, which adds to the Hospital Licensing Act a definition of medical staff privileges. They are defined as permission to provide medical or other patient care services and the ability to use existing hospital resources, like equipment and personnel, that are necessary to provide those services. The bill was sponsored by Reps. Miguel Santiago (D-Chicago) and Mark Beaubien Jr. (R-Wauconda) and Sen. William Mahar (R-Orland Park). It passed both chambers and will be considered by the governor.

The Society supported H.B. 382, a bill that prohibits intact dilatation and

extraction, or partial-birth abortion. The proposal bans intact D&X unless it is necessary to save a mother whose life is threatened by a physical disorder, illness or physical injury and unless no other medical procedure would suffice. Rep. Peter Roskam (R-Wheaton) and Sen. Chris Lauzen (R-Geneva) sponsored the measure, which is on the governor's desk.



ISMS House of Delegates' positions led to several anti-smoking bills that were blocked from passage by the influential tobacco lobby. One ISMS measure, however, advanced from the House but later stalled in the Senate. H.B. 570, sponsored by Rep. Daniel Burke (D-Chicago) and Sen. Christine Radogno (R-LaGrange), would have banned smoking in all health facilities including hospitals and doctors' and dentists' offices. Two other anti-tobacco measures – one that banned

smoking in all restaurants and one that prohibited the distribution of free tobacco samples – didn't advance from the House.

During the summer, the Senate is expected to develop a tobacco-related bill that will be considered during the fall veto session.

Another bill originating from an ISMS position is S.B. 247, sponsored by Sen. Dave Syverson (R-Rockford) and Rep. Dave Winters (R-Rockford). This bill, which passed both chambers, would require only positive results of lead poisoning tests to be reported within 48 hours to the Illinois Department of Public Health. ■



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REPORT for Illinois Physicians

MEDICARE

REFRACTIVE KERATOPLASTY- NOT COVERED

Refractive keratoplasty is surgery to reshape the cornea of the eye to correct vision problems such as myopia (nearsightedness) and hyperopia (farsightedness). Refractive keratoplasty procedures include keratomileusis, in which the front of the cornea is removed, frozen, reshaped, and stitched back on the eye to correct either near or farsightedness; keratophakia, in which a reshaped donor cornea is inserted in the eye to correct farsightedness; and radial keratotomy, in which spoke-like slits are cut in the cornea to weaken and flatten the normally curved central portion to correct nearsightedness.

The correction of common refractive errors by eyeglasses, contact lenses or other prosthetic devices is specifically excluded from coverage. The use of radial keratotomy and/or keratoplasty for the purpose of refractive error compensation is considered a substitute or alternative to eye glasses or contact lenses, which are specifically excluded by Section 1862 (a)(7) of the Social Security Act (except in certain cases in connection with cataract surgery). In addition, many in the medical community consider such procedures cosmetic surgery, which is excluded by Section 1862 (a)(10) of the Act. Therefore, radial keratotomy and keratoplasty to treat refractive defects are not covered.

Keratoplasty that treats specific lesions of the cornea, such as phototherapeutic keratectomy that removes scar tissue from the visual field, deals with an abnormality of the eye and is not cosmetic surgery. Such cases may be covered under Section 1862(a)(1)(A) of the Act.

The use of lasers to treat ophthalmic disease constitutes ophthalmologic surgery. Coverage is restricted to practitioners who have completed an approved training program in ophthalmologic surgery.

Supreme Court considers tort reform

PAGE 1

ISMIE Update

High court lowers burden of proof to take med mal cases to trial

PAGE 3

Rules of thumb for record retention

Physicians should know what the state law and statutes of limitations require. BY CHRIS PETRAKOS

When it comes to retaining patient records, at least one attorney says physicians should "keep all patient records forever – end of story." That is the safest risk management advice, but storing everything indefinitely may also be impractical.

To help physicians determine how long to keep records, ISMS offers members a free handbook called "A Physician's Guide to Medical Record Access and Retention." Recommendations in the pamphlet are based on Illinois law including statutes of limitations on damages. For example, the booklet advises retaining records for four years from the last contact with patients, because plaintiffs are allowed to seek action for damages up to four years from the time of an injury, according to the state statute of limitations. For patients who are under 18 years old, the statute of limitations is longer, and accordingly, the pamphlet suggests keeping those records for



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at least eight years from the last contact with those patients.

Pat Foltz, an attorney at Lord, Bissell and Brook in Chicago, said it is up to physicians to decide what constitutes

the last contact with patients. "What is important is that this policy needs to be written," she said. "Don't just say it. Otherwise, staff will not follow it uniformly. Keep in mind there may

arguably be a common-law duty to retain records if you don't have a policy that states, for example, that you will dispose of them within a certain period. The policy should be signed by the people who administratively run the office and are in charge of the practice. Then, the office staff have to be made aware of it."

In developing retention policies, physicians must be aware of exceptions to the four- and eight-year guidelines. For example, under the Mental Health and Developmental Disabilities Confidentiality Act, patients with permanent disabilities – including mental health disabilities – have the right to sue physicians at any time regardless of when their injuries occurred, so those patients' records should be retained indefinitely, according to the ISMS pamphlet. In addition, the National Childhood Vaccine Injury Act dictates that all immunization records going back to March 1988 be retained indefinitely.

X-ray retention is governed by the X-ray and Roentgen Photographs Act, according to David Drake, an attorney with Drake, Narup and Mead in Springfield. "In Illinois, X-rays and roentgen photographs should be held for five years unless they involve a minor. And if there is litigation pending near the five-year mark, they should be held for 12 years or until the case has been closed."

Mammograms must be kept in a patient's records for no fewer than five years, according to the U.S. Food and Drug Administration. If the patient has had no additional mammograms performed at the physician's office or pending the patient's requested permanent transfer of her records, the images must be maintained for at least 10 years.

After the retention policy is in place, staff should review records biannually, Foltz said. Even when physicians have decided to dispose of patient files after a certain amount of

ISMIE to hold seminar on impact of litigation

To help physicians cope with the stress of medical malpractice litigation, ISMIE is inviting its policyholders who are currently involved in open medical malpractice claims or lawsuits to attend a seminar on July 16. "Understanding and Coping with the Impact of Malpractice Litigation" will be held from 2 p.m. to 5 p.m. at ISMS headquarters at 20 N. Michigan Ave. in Chicago.

The program helps physicians pinpoint the causes of stress related to litigation, recognize common stress responses and identify sources of support. Sara Charles, MD, emeritus professor of psychiatry at the University of Illinois, will present the seminar.

Policyholders who have not received their invitations or who would like more information may call the ISMIE Risk Management Division at (312) 782-2749 or (800) 782-4767, ext. 1394.

MALPRACTICE ROUNDUP

Jury awards \$9.45 million for error in infant's delivery

A New York City hospital has been ordered to pay \$9.45 million to the mother of a baby delivered vaginally when a cesarean section could have reduced trauma and injury to the infant, according to the April 14 edition of the National Law Journal.

In *Rosa vs. New York City Health and Hospitals Corp.*, the plaintiff attorney said the patient's water had broken before she arrived at the hospital. But the hospital staff didn't recognize that fact and administered Pitocin to induce labor. The baby was delivered vaginally more than 24 hours later with permanent neurological injuries including cerebral palsy. The plaintiff attorney claimed the drug and the stress on the fetus led to the infant's injuries. The hospital's counsel contended that the baby experienced problems because of her premature birth at 31 weeks.

A Bronx jury awarded the plaintiff \$9.45 million, including \$4.5 million for future care and loss of earnings. The defense is seeking to reduce the award or set aside the verdict.

Jury finds carotid injury is complication of disk surgery

A Georgia jury found for the defense in a case in which a patient's carotid artery was damaged during disk surgery, according to the May issue of *Medical Malpractice Law & Strategy*.

In *Harper vs. Flinchum, Cross, Powell, P.C.*, the defendant physician burned a hole in the plaintiff's carotid artery with a surgical instrument during an anterior cervical discectomy. The damage caused profuse bleeding, but the physician and a vascular surgical team repaired the hole.

The patient recovered but alleged that the physician failed to exercise proper care in performing the procedure. The physician, however, said that he met or exceeded the standard of care and that the injury is a recognized complication of this type of surgery.

time, the office must still maintain some basic information. "Keep a sheet of paper that says the patient had been [with the practice]," Foltz said. The retained information must include the dates of the patient's first and last visits, date of birth, Social Security number, and the general problems and procedures done in the office.

If files aren't retained appropriately, the result may be claims of spoliation, whereby plaintiffs charge that evidence was destroyed that physicians had a duty to retain. "The bottom line is that you should be careful to keep these things to the extent that you're required," Drake said.

To get a copy of "A Physician's Guide to Medical Record Access and Retention," call the ISMIE Risk Management Division at (312) 782-2749 or (800) 782-4767, ext. 1327. ■

Highlights of the General Assembly's spring 1997 session

Photos: Ron Ackerman



Bill	Summary	Outcome	ISMS' position
S.B. 8	Lowers drivers' legal blood alcohol content from .10 to .08.	Passed	Supported
S.B. 160, H.B. 725	Defines health care payers and exempts them from civil or criminal liability for refusing or arranging to pay for any health care services that violate their conscience.	Passed	Supported
S.B. 234	Allows at least one director on a hospital district board to also be a member of a district hospital medical staff.	Passed	Supported
S.B. 247	Requires only positive results of a lead poisoning test to be reported within 48 hours to the Illinois Department of Public Health.	Passed	Supported
S.B. 314	Prohibits the practice of telemedicine without an Illinois medical license.	Passed	Supported
H.B. 8	Bans insurers and employers from using genetic information to discriminate in health coverage and employment.	Passed	Supported
H.B. 106	Makes female genital mutilation a criminal offense.	Passed	Supported
H.B. 382	Bans intact dilatation and extraction.	Passed	Supported
H.B. 408	Defines privileges that are granted with hospital medical staff membership.	Passed	Supported
H.B. 1881*	Requires insurance policies not exempted under ERISA to cover annual mammograms for women age 40 and older, annual pap tests, annual prostate-specific antigen tests and inpatient care for mastectomy patients for a time determined by the attending physician according to scientifically developed protocols.	Passed	Supported
S.B. 781	Allowed parents or legal guardians to object to health exams and immunizations of school-age children on philosophical grounds.	Stalled in Senate	Opposed
H.B. 73	Created physician profiling program with profiles including malpractice lawsuit data.	Failed	Opposed
H.B. 118	Mandated hospitals with 250 or more licensed beds to staff one physician in addition to an emergency physician at all times.	Failed	Opposed
H.B. 628	Changed law to permit interest on lawsuit judgments to begin accruing when an accident or negligent event occurred instead of when judgment was rendered.	Failed	Opposed
H.B. 1026	Extended retention of X-ray record requirement from five years to nine. Added CT scan, MRI, MRA, PET, ultrasound and mammography films to types of records that must be stored.	Failed	Opposed
H.B. 1042	Created the Managed Care Responsibility to Members Act, supported by the Illinois Association of Health Maintenance Organizations.	Failed	Opposed
H.B. 1078	Defined advanced practice registered nurses and their scope of practice.	Failed	Opposed
H.B. 1623	Regulated the practice of direct entry midwifery through certification requirements.	Failed	Opposed
H.B. 1828	Established demonstration program requirements for birthing centers.	Failed	Opposed
H.B. 111	Required insurers to offer equivalent coverage for serious mental illnesses and physical illnesses.	Stalled in Senate	Supported
H.B. 570	Banned smoking in all hospitals, ambulatory surgical treatment centers and postsurgical recovery centers, dentists' and doctors' offices, and other health care facilities. Exempted nursing homes.	Stalled in Senate	Supported
H.B. 626	Created a comprehensive managed care reform bill that included portions of ISMS' Managed Care Patient Rights Act.	Stalled in Senate	Supported
S.B. 705, H.B. 603	Created the Managed Care Patient Rights Act. Guaranteed patients the rights to quality, choice, individual respect, advocacy and information.	Failed	Supported
H.B. 365	Exempted physicians from civil liability for providing emergency care at sporting, religious or public events.	Failed	Supported
H.B. 567	Banned tobacco use in restaurants.	Failed	Supported

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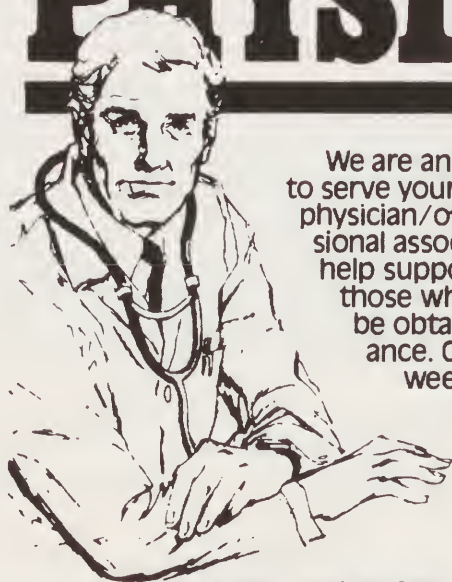
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Session ends

(Continued from page 1)

appealed a plan decision or requested a due process hearing. Plans would have to notify physicians in writing about the reasons for contract termination.

Schoenberg said many lawmakers believe more discussion is still needed. "We have over the past few months been able to iron out some areas of disagreement that would result in making HMOs more responsive to patients and enabling physicians to practice medicine less defensively. But this issue will require further negotiation and discussion over the summer months. I anticipate that because of the magnitude of managed care reform, key House and Senate committees will be taking a renewed look at the issue in the Legislature's fall veto session."

ISMS President Jane Jackman, MD, testified at the first hearing of the Senate

Managed Care Subcommittee in late April. Also testifying were representatives of business groups, the Illinois Association of HMOs and the Illinois Hospital and HealthSystems Association. Sen. Thomas Walsh (R-Westchester), the subcommittee's chairman, said that more subject matter hearings are planned, but no dates or sites had been announced as this issue of Illinois Medicine went to press.

Dr. Jackman said ISMS will work with legislators throughout the summer to find legislative solutions to the managed care problems that legislators have heard about from their constituents.

"We remain open to new ideas and more-effective mechanisms for assuring our patients their health care rights."

Also during the spring session, IAHHMO introduced H.B. 1042 as its own limited version of managed care reform. That bill failed to advance from the House by the deadline for action. H.B. 1042 was criticized for preserving the status quo by offering patients only the rights they already have under existing laws and practices.

In addition, legislators considered many bills dealing with specific aspects of reform, but most of those bills stalled. Some called for improved access and

coverage for specialty care, and others required coverage for diabetes self-management training, nonprescription foods for gastrointestinal treatment and care for investigational cancer treatments.

One bill that did advance is H.B. 1881, which mandates that insurance policies other than ERISA-exempt employer plans cover annual mammograms for women who are 40 or older, annual Pap tests, annual prostate-specific antigen tests and inpatient care following a mastectomy for a time to be determined by the attending physician according to scientifically developed protocols. The measure was signed by the governor on June 10. ■

Supreme Court hears

(Continued from page 1)

curiae briefs from tort reform supporters but did decide to review three joint briefs from six organizations that oppose the law. Those organizations filing joint briefs were the Brotherhood of Heat and Frost Insulators, Local 17, and the Southeast Environmental Task Force; the National Association for the Advancement of Colored People, Chicago Southside Branch, and the Cook County Bar Association; and the Illinois NOW Legal and Education Fund, and the Breast Implant Information Exchange.

"I was surprised that the Illinois Supreme Court would only allow friend of the court briefs from a number of dogooder groups and not those from entities such as the Illinois Manufacturers' Association, which employ thousands of our state's taxpayers," said Sen. Kirk Dillard (R-Downers Grove), one of the law's sponsors.

That unusual step was inconsistent with the Supreme Court's actions during deliberations on 1975 and 1985 tort reform legislation. In 1975, the Legislature passed reforms that included a \$500,000 cap on combined economic and noneconomic damages. During that legal debate, the court permitted ISMS and the City of Chicago to submit amicus curiae. The court subsequently struck down the cap.

Ten years later, the Supreme Court upheld tort reforms passed by the General Assembly, which didn't include a cap on noneconomic damages. Then, too, the justices accepted briefs from tort reform supporters and opponents. "The clear history and track record [of the Supreme Court] has been to let in both sides," said ISMS General Counsel Saul Morse.

In the current tort reform debate, Illinois Attorney General Jim Ryan used his office's constitutional right as an "intervenor" to be heard.

At least 17 cases challenging the constitutionality of the 1995 tort reform law await the court's decision, and several others are pending in lower courts. Murnane said the court "has scheduled briefs and held oral arguments faster than might otherwise have been anticipated, and we think one reason is that there is somewhat of a backlog of cases awaiting resolution." The Supreme Court stayed all other pending tort reform cases until it issues a ruling in the Best case. ■

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Chicago-area
IPA allows
physicians to
steer health care

PAGE 8

Illinois Medicine

ILLINOIS STATE MEDICAL SOCIETY • JULY 18 1997

Society
receives
reaccreditation
for CME

PAGE 2

State merges governmental services

EFFICIENCY: Savings
will be invested in
prevention program.

BY JANE ZENTMYER

[SPRINGFIELD] On July 1, the Illinois Department of Human Services made its official debut, about 18 months after Gov. Jim Edgar first proposed the idea and just over a year since the General Assembly signed off on the plan. The new department, with a \$4.3 billion budget and about 20,000 employees, will allow Illinoisans to do one-stop shopping for governmental services.

IDHS was formed by combining the Department of Alcoholism and Substance Abuse, the Department of Mental Health and Developmental Disabilities and the Department of Rehabilitation Services. The new agency also absorbed programs from other state departments, including employment-related child care and youth services from the Department of Children and Family Services; the Women, Infants and Children program, family case management and other health-related direct service and prevention programs from the Department of Public Health; and cash assistance, food stamps, Medicaid eligibility determination, employment programs, child care and social service programs from the Department of Public Aid.

"This idea of one-stop shopping means that the office will link you with and refer you to [other services] and is going to take a more holistic view of you and your family," said Ann Patla, associate secretary of IDHS. However, individuals may still visit one of the 137 IDHS offices in Illinois for particular services, such as obtaining a Medicaid card, she said.

IDHS estimates that more than 1.5 million people will use its programs. The consolidation of state services is expected to save \$2 million in fiscal year 1998, and the savings will be

(Continued on page 14)

State high court allows ISMS, ICJL amici

VICTORY: Campaign for fairness leads to permission to file previously denied friend-of-the-court briefs.

BY JANE ZENTMYER

[SPRINGFIELD] On July 11, the Illinois Supreme Court entered an order permitting all previously denied amicus curiae briefs to be filed by Aug. 1 in *Best vs. Taylor Machine Works*, the case being used by the court to determine the constitutionality of the entire 1995 tort reform law. The court had previously accepted briefs from only opponents of the law. "It is unprecedented in my experience for the Supreme Court to so radically change course," said ISMS General Counsel Saul Morse. "It would seem the public concerns voiced by the Illinois Civil Justice League and ISMS have had an effect on the court."

Just 10 days prior to the court's decision, the Illinois Civil Justice League announced a campaign to alert Illinoisans to the facts that supporters of the 1995 law had not been allowed to file amici in the case and that a fair

process is essential to a fair decision. ICJL President Ed Murnane made the announcement at a Springfield news conference that was attended by the media and representatives of ICJL member organizations including ISMS. As part of the campaign, full-page ads were placed in statewide newspapers the following day. (The ad appears on page 5 in this issue.)

Tort reform supporters that were previously denied access included ISMS, the Illinois Manufacturers' Association, the Illinois Hospital and HealthSystems Association, the Product Liability Advisory Council Inc., the Illinois Association of Defense Trial Counsel and three separate requests from ICJL. The only proponent who filed a brief was Illinois Attorney General Jim Ryan, using the office's legal right as an "intervenor" to do so. Justices heard oral argu-



MURNANE ANNOUNCES the ICJL campaign at a July 1 news conference in Springfield as ISMS President Jane Jackman, MD, listens.

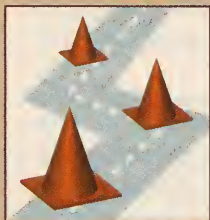
ments on May 21, and a decision could come at any time.

At the July 1 news conference, Murnane explained the coalition's concerns about the preliminary process in the case.

"We are concerned and more than a little disappointed that the court has refused to allow any of the supporters of the tort reform act to submit amicus (Continued on page 14)

INSIDE

Watch for
obstacles on road
to diagnosing MI



PAGE 7

Workers' comp
process raises
concerns

PAGE 6

DEPARTMENTS

Classifieds11

IDPR

Disciplines13

HCFA proposes Medicare payment rule that would affect practice expense

RBRVS: Changes may become effective in January. BY JANE ZENTMYER

[CHICAGO] The U.S. Health Care Financing Administration released a proposed rule on June 18 that outlines the 1998 RBRVS fee schedule. Fee schedule changes include the first revision of the practice expense portion of Medicare payments. HCFA will accept comments for possible inclusion into the rule until Aug. 18 with plans for the rule to become effective Jan. 1.

To determine Medicare payment for services, HCFA takes into account a physician's time spent on a procedure, professional liability insurance payments and practice expenses like overhead and personnel. A relative value is then assigned, and that figure is eventually used to determine the payment for a service. "The challenge is that although it's easy to come

up with what's involved in terms of work in providing a service, it's much harder to figure out what component of your practice expenses would go into figuring that," said John Schneider, MD, chairman of ISMS' Third Party Payment Processes Committee.

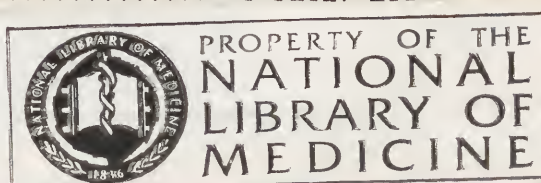
Federal law requires HCFA to develop a new payment methodology for practice expenses for 1998. To meet that requirement, HCFA began by surveying panels of physicians, practice administrators and others, and collecting data on prac-

tice costs, according to an ISMS analysis.

The AMA has questioned the accuracy of the data used to determine new practice expense values. "A number of practice expenses are totally unaccounted for in HCFA's proposed relative values. Staff such as office managers and quality control personnel are not counted in the proposed relative values because these costs cannot be attributed to specific procedures," said AMA President-elect Nancy Dickey, MD, in a letter to (Continued on page 15)

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ISMS to continue sponsoring accredited CME programs

ACCME reaccredits Society for four more years. BY JANE ZENTMYER

ISMS was granted accreditation for another four years by the Accreditation Council for Continuing Medical Education last spring, allowing the Society to continue designating programs for CME. "ACCME accreditation seeks to assure both physicians and the public that continuing medical education activities sponsored by ISMS meet the high standards of the Essentials and Standards for Accreditation as specified by the ACCME," according to the council's news release.

This year's accreditation reaffirms ISMS' commitment to help physicians with their medical education. In 1996, the Society offered 74 activities with a total of 166.5 CME hours to the 1,340 physicians who participated. These programs included ISMIE risk management seminars and ISMS leadership symposiums.

Reaccreditation became even more important this year with the passage of the revised Medical Practice Act, which requires physicians to earn 50 hours of CME per year in order to renew their medical license, according to Dean Bor-

deaux, MD, chairman of ISMS' Committee on CME Activities. With the reaccreditation, ISMS can continue to sponsor programs that benefit physicians professionally, including helping them fulfill the new CME requirement. "It's not only for licensure; some professional associations and the boards also require CME for continued membership or for board certification," Dr. Bordeaux said.

In evaluating groups that offer CME programs, ACCME uses standards adopted by its seven sponsoring organizations: the American Board of Medical Specialties, the American Hospital and HealthSystems Association, the American Medical Association, the Association for Hospital Medical Education, the Association of American Medical Colleges, the Council of Medical Specialty Societies and the Federation of State Medical Boards. The accreditation process is voluntary.

ISMS began the process in late 1996 and met with ACCME representatives last February. The Society had to provide documentation to show it meets ACCME's



DOCTORS FROM DOWN

under – Australian Medical Association officers David Brand, MD (left) and Bill Coote, MD (center) – meet with James Downey, MD, in his Evanston office on June 19. The Australian physicians met with Illinois doctors to discuss managed care while they were in town for the American Medical Association's annual meeting.



John McNulty

requirements, Dr. Bordeaux said. "First, you have to show how we identified the needs of the physicians who are going to participate and how we then translated those needs into learning objectives." From there, the Society had to show how it would help physicians accomplish those objectives. After the program is presented, ISMS must evaluate whether the objectives were achieved and show how that evaluation information was used to plan future programs, he explained.

ACCME allows organizations to decide whether to offer CME courses by interviewing prospective participants and analyzing their self-assessment results, epidemiological data, patient care audits, a search of current literature or consensus of experts in a particular field. For example, a recent ISMIE seminar on

myocardial infarction was partly based on a review of closed claims data that showed a need for a seminar reviewing clinical information and risk management techniques.

ACCME determines whether the programs meet rules for commercial support, Dr. Bordeaux said. "That's to prevent conflict of interest or commercial bias in the presentation." To meet the standard, program materials must include the name of the activity's commercial supporter and disclose any financial relationships, he explained. "The intent is [to allow] the participant to make a decision as to whether there has been commercial bias."

ISMS will be reviewed again in four years with an on-site survey, Dr. Bordeaux said. ■

ISMS resident, student councils elect officers

[OAK BROOK] The ISMS Resident Physicians and Medical Student sections' governing councils elected officers during April meetings conducted in conjunction with the ISMS House of Delegates Annual Meeting in Oak Brook.

The Resident Physicians Section elected Betty Chang, MD, Chicago, as president for the 1997-98 term. Other new officers are Vice Chairman Robert Oliver, MD, of Springfield; Secretary-Editor Joilo Barbosa, MD, LaGrange Park; Delegate Nani Golden, MD, Chicago; and Alternate Delegate Becky Bezman,

Chicago.

The Medical Student Section named Northwestern Medical School student Sanjay Saxena of Chicago as chairman for the 1997-98 term. Other officers elected are Vice Chairman Harsh Sule, a student at the University of Illinois at Chicago; Secretary Elizabeth Bundock, a student at Chicago Medical School in North Chicago; Delegate Jennifer Vietri a student at Loyola University's Stritch School of Medicine; and Alternate Delegate Dao Nguyen, a student at the University of Illinois at Rockford. ■

Free student athlete exam forms available

[BLOOMINGTON] The Illinois High School Association offers free forms to physicians who perform examinations of high school athletes.

Illinois schools are required to have a physician-signed certificate of physical fitness on file yearly for each student participating in IHSA-sanctioned athletics, according to IHSA Executive Director David Fry.

"Medically and legally, it is important to have this form to draw attention to the fact that the physician has gone through the steps," said Patrick Wolin, MD, a Chicago orthopedic surgeon who worked with IHSA to develop the forms. Dr. Wolin said IHSA will accept a note from a physician "saying that the student is OK to play on the team. But how will the physician be able to say he followed through with a complete exam without the appropriate records?"

At the recommendations of an IHSA sports medicine committee, the state association revamped the forms in 1993 to reflect a broader range of health concerns.

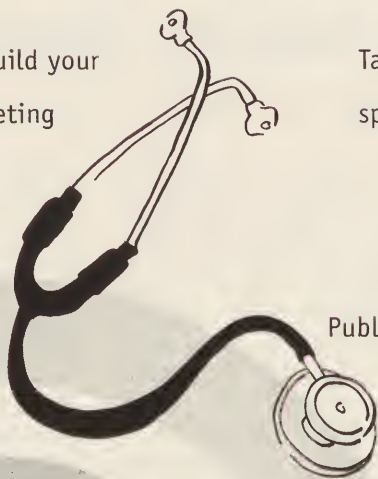
Now, students and their parents must include and sign a medical history, including disclosure of personal habits such as the use of tobacco, alcohol, recreational drugs and steroids, said IHSA Associate Executive Director Donald Robinson.

To get copies of the forms, contact the IHSA at 2715 McGraw Drive, P.O. Box 2715, Bloomington, IL 61702-2715; or call (309) 663-6377. ■

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Illinois' first lady launches women's health campaign

LEGISLATION: Governor signs bill allowing physicians to determine length of stays for mastectomy patients. BY JANE ZENTMYER

[CHICAGO] Illinois' first lady Brenda Edgar kicked off the Illinois Women's Health Campaign on June 10 to raise public awareness about the health needs of women, especially those 40 and older. The campaign focuses on informing Illinoisans about heart disease, breast cancer, osteoporosis, menopause, mental health and domestic violence. The event was held at Marshall Field's State Street store in Chicago.

"I am not an expert on women's health care," Edgar said. "But I'm experienced at being a woman, a woman who is facing many changes all at once — some physical, some psychological, all frustrating. Change can be good, but all too often change can be frightening and confusing for women at mid-life."

Gov. Jim Edgar, who announced his wife's initiative in his January state-of-the-state address, also attended the event to sign H.B. 1881. The ISMS-supported law requires all insurers not exempted under ERISA to cover annual mammograms for women 40 and older, Pap tests and prostate-specific antigen tests. In addition, it mandates that insurers pay for inpatient care of mastectomy patients for a period of time to be determined by the attending physician.

The governor spoke at the June 10 kickoff about the importance of the women's health initiative: "There is so much that needs to be done, and government can't do it all."

The campaign brings together a coalition of more than 25 governmental agencies and professional and lay organizations, including ISMS, to accomplish its goal. Corporate sponsors Blue Cross and Blue Shield of Illinois, Pfizer Inc. and State Farm Insurance will help pay for the public awareness materials.

"The results of this campaign could be to positively affect the relationship women have with their doctors because women will become increasingly diligent and better informed about their own health care needs," said ISMS immediate past President Sandra Olson, MD, who represents the Society on the coalition.

The first lady said the Illinois campaign has its roots in a nationwide women's health effort started by the National Governors' Association Spouses Program. In Illinois, the campaign is coordinated by the new Office of Women's Health, which is part of the Illinois Department of Public Health. The office's deputy director is Sharon Green, the former executive director of the Y-ME National Breast Cancer Organization.

"It is my hope that the Office of Women's Health will lead the way to the creation of a statewide network for women's health care advocates," Green said. She will also serve as chairman of a women's health council, which will include representatives from several state agencies and will coordinate the services of those agencies.

The Illinois program offers a toll-free hot line that women can call to access a clearinghouse of information about

women's health and to get answers about their health concerns. Callers may also be referred to local community resources. The hot line number, (888) 522-1282, is operational Monday through Friday from 8 a.m. to 9 p.m. ■

GOV. JIM EDGAR signs into law H.B. 1881 as first lady Brenda Edgar (far right) looks on. ISMS supported the bill, which addresses insurance coverage of hospital stays for mastectomy patients, mammograms, Pap tests and prostate-specific antigen tests.



Terry Vitacco



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REPORT for Illinois Physicians

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Mission Statement of Blue Cross and Blue Shield of Illinois (BCBSI) makes significant commitments to the providers, payors, and patients of Illinois. It states that:

The mission of BCBSI is to have a positive impact on the quality, cost effectiveness and accessibility of health care. BCBSI will accomplish this mission through its role as a provider of the highest quality health care financing and administration, benefit programs, and related services for employees and beneficiaries of client organizations and individual customers.

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To positively impact the quality of health care by understanding and meeting the expectations of key customers so as to attain continuous improvement in the process and outcomes of care, the satisfaction of members and providers, and the costs of health care services.

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BCBSI recognizes the importance of, and is committed to, treating its members in a manner that respects their rights and makes clear their responsibilities in the area of health care service. As a result, clear policies and procedures exist that delineate, among other matters, the nature of the information which is supplied to members about their health care plan, appeal and grievance mechanisms, standards for access to services, and confidentiality. These policies are shared with providers and members.

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EDITORIAL

Reversing a lost cause

Some might have thought it was a lost cause. In deliberating the constitutionality of the 1995 tort reform law, the Illinois Supreme Court had decided to accept amicus curiae briefs from only the law's opponents. We could have accepted that just one side was going to be heard and given up on the issue despite the unfairness.

But members of the Illinois Civil Justice League, including ISMS, didn't give up. We united and tried to make the public aware of the situation. League members held a news conference on July 1 to alert all Illinoisans to the importance of the issue and to announce an ad campaign that would begin the next day. The event generated news coverage that supplemented ICJL advertisements published in several newspapers statewide.

Less than two weeks after that news conference, the Illinois Supreme Court changed its previous decision and permitted all previously denied amicus briefs to be filed, with a deadline of Aug. 1. Legal experts say that the reversal is unprecedented. It reflects the court's willingness to reconsider its stance, which should be applauded, and the importance of publicly explaining our position on such issues.

Most of that explanation was disseminated by ICJL, but support even came from an unexpected source. The Chicago Council of Lawyers released a statement that "by refusing to accept amicus briefs, the court unnecessarily shuts off discussion on issues that ultimately affect near-

ly all persons in Illinois. Allowing amicus briefs gives interested persons and groups the ability to be heard within the judicial system."

ICJL members worked in concert on the issue and brought out different critical points at the news conference. The Illinois Hospital and HealthSystems Association noted that the parties in this particular lawsuit, which deals with product liability, have absolutely no interest in medical malpractice provisions and that in such cases, the Supreme Court has historically allowed amicus briefs to be filed. The lawsuit deals with a narrow area of the law, yet the court's decision may affect even unrelated provisions of the law. The Illinois Manufacturers' Association stated that the court accepted three briefs that opposed tort reform and that raised issues that emerged from the 1995 legislative debate; supporters of the law deserved the same opportunity.

ISMS President Jane Jackman, MD, reinforced the importance of amicus briefs in rulings, citing a recent U.S. Supreme Court decision with wording similar to that of an amicus brief submitted by the AMA.

The court's decision to hear from both sides is a victory, and credit certainly goes to the court and ICJL. But we need to keep this victory in perspective, recognizing that the court hasn't yet decided on the constitutionality of the law and this was just one battle in our efforts to preserve comprehensive tort reform.

PRESIDENT'S LETTER

Tort reform is good medicine for Illinois patients

Jane L. Jackman, MD



Let's remember that it took us 20 years to get where we are today, and we are not about to give up easily!

Getting a large group of doctors to agree on any issue can be challenging, but one issue that has consistently united us has been the absolute need for malpractice lawsuit reform. On July 11, the Illinois Supreme Court decided to allow amicus curiae briefs from supporters of tort reform that had previously been denied access to the court in a landmark case being used to test the constitutionality of the 1995 tort reform law.

The Illinois Civil Justice League, a coalition of businesses and medical and service organizations (even the Girl Scouts!), waged a media campaign that stressed the need for fairness in hearing both sides in the debate. The court had previously allowed only opponents of the law to file amicus curiae briefs, but less than two weeks after the ICJL news conference, the court agreed that proponents could also file friend-of-the-court briefs.

The fight for tort reform actually began 22 years ago. In 1975 we attempted to change Illinois law and even worked toward passage of a cap on all damage awards. Subsequently, however, those reforms were ruled unconstitutional by our state Supreme Court. With the crisis in medical malpractice insurance intensifying, though, we pressed on, and supported passage of many meaningful changes in 1985 and 1986, including limits on attorney fees, periodic payment of awards, certificate of merit reforms and so on. Fortunately, most of these new laws were approved by the Supreme Court. However, the key to completing tort reform, i.e., caps on pain and suffering awards, eluded us until we joined ICJL to pass the final phase of tort reform in 1995.

Of course, we expected challenges to the new law, as happened in the past. Sure enough, the first lawsuit was filed just minutes after Gov. Edgar signed the new law. The first challenge to the constitutionality of the law was heard by the Illinois Supreme Court this spring. Oral arguments in the case of Best vs. Taylor Machine Works were presented on May 21. However, there was a major difference this year. In 1975 and

1985, the Supreme Court allowed ISMS to file amicus curiae briefs for the defense, so it was not only disappointing, but also shocking when we were initially not allowed to file a friend-of-the-court brief. Other tort reform advocates were also previously precluded from filing.

The court did allow three parties to file petitions for the plaintiffs. These were presented by the National Association for the Advancement of Colored People, the Brotherhood of Heat and Frost Insulators, Local 17, and the Illinois National Organization for Women Legal and Education Fund. They argued that tort reform discriminates against women, because they generally earn less than men, and blacks, because they may earn less than whites and may have more hazardous jobs. Ironically, we had previously used the argument that the lack of tort reform discriminated against women (in rural areas who had no one to deliver their babies) and blacks (in inner cities who lacked access to medical care). The Illinois Farm Bureau supported our contention that the high cost of liability insurance deterred young doctors from practicing in underserved areas of Illinois.

Let's remember that it took us 20 years to get where we are today, and we are not about to give up easily! It may help to look at what has happened in states like California. In 1975, the California Medical Association developed comprehensive tort reform legislation, which helped lower the cost of liability insurance, increase access to care and stabilize the cost of medical care. In fact, our tort reform package is based on California's legislation. But every year since 1975, CMA has had to beat back legal and legislative challenges to the law. So, experience tells us that even when a cap on noneconomic awards is found constitutional in Illinois, the fight to keep it will be ongoing.

ISMS and ISMIE will continue to make tort reform the top priority, because we know how important it is to you, our members. We will prevail, if not this year, certainly in the near future, because we believe that tort reform is good medicine for Illinois patients.

A fair process is essential to a fair decision



That's why Illinoisans should be concerned

over the way the **Illinois Supreme Court** has been considering the challenge to the new lawsuit reforms passed in 1995.

The Court refused to grant "friend of the court" status to any reform supporters—people and organizations with good, sound legal arguments and theories they wanted to share, so the Court would have all the information necessary when considering the challenge.

More curiously, it granted that status to several organizations that oppose the new law.

It's no surprise that the law was challenged. Powerful special interests that profit from the explosion of lawsuits think they have a lot to lose from reform.

What's surprising is the way the Court has chosen to limit the debate. **Shutting one side out** appears neither fair nor impartial.

Certainly, this does not mean the Court made up its mind before it even considered the case.

Perhaps the Court already knows why the General Assembly, with widespread public support, decided the new law was necessary: frivolous lawsuits were clogging the courts and raising the costs of goods, services and taxes to every Illinois citizen by an extra \$1,000 a year.

And perhaps the Court will weigh the forceful and logical arguments Illinois Attorney General Jim Ryan made on behalf of the new law.

If that's the case, so be it. But a Supreme Court that has faced up to controversy in the past shouldn't want to create **new questions and doubts** by closing off the process.

— *The 360 members of The Illinois Civil Justice League and the millions of Illinois citizens whom they represent.*



Workers' comp process raises physician-patient concerns

WORK-RELATED INJURIES: Cost containment may clash with quality of patient care. BY CHRIS PETRAKOS

[CHICAGO] The physician-patient relationship is at the heart of the practice of medicine, but when a patient is seeing a physician through workers' compensation, other parties are involved — namely, the patient's employer and the insurance carrier. Those parties are understandably concerned about cost containment, but those concerns may run counter to providing the highest quality of care for patients. That's why it's especially important for patients and their physicians to know how the system works and what the options are.

In Illinois, employees injured on the job are entitled to choose any doctor or hospital at their employers' expense, according to the Illinois Industrial Commission, the organization that oversees workers' comp cases. The employer must pay for all first aid and emergency services, two treating physicians, surgeons and hospitals chosen by the employee, and any additional medical care providers to whom the employee is referred by the two physicians, surgeons or hospitals. Once the employee makes the choices that are allowable, he or she must get the employer's approval for additional doctors or hospital services. In addition, the employer can ask for an

evaluation to be done by a doctor whom the employer chooses and compensates.

Cost-cutting pressures and some incidences of patient fraud have caused employers and carriers to become more

vigilant, so physicians need to be especially careful to educate patients about their options, according to Chicago orthopedic surgeon Michael Treister, MD. "I always tell the patient on

the first visit that the company has the right to send them for another opinion to someone else, but can't mandate that they go for treatment with someone else. I make a point of telling them that they have control of the situation."

Rehabilitation nurses or vocational counselors assigned by the insurance carriers have become part of the workers' comp process, usually to determine that the employees are receiving appropriate treatment. If a dispute arises over a carrier's decision to cease workers' comp benefits, the case can be arbitrated before the Illinois Industrial Commission. First, though, an independent medical examin-

er is brought in to provide an unbiased summary of the patient's injury, diagnostic tests and treatment, according to industrial commission arbitrator Valerie Peiler.

Insurance industry officials didn't respond to requests for interviews.

Dr. Treister said he makes sure his documentation is especially clear and detailed because the records may be evaluated by an examiner or rehab nurse, and that evaluation will affect the course of treatment for the patient.

I make a point of telling patients that they have control of the situation.

"For example, I'll write, 'Patient has clinical findings of a disc herniation, but we have not yet received permission from the insurance company for an MRI. I would not return

this person to work unless I know status of disc, and therefore we need to get the MRI.'"

If the case reaches the arbitration stage, Dr. Treister also explains to patients that they're going for an independent medical examination and that this physician will evaluate the injury and treatment before issuing an opinion. But he also tells them, "They can't give you a prescription; they can't order you to have an injection; and they can't give you a return-to-work slip."

Treatment can be complicated by the use of rehab nurses, according to E. Richard Blonsky, MD, a Chicago neuro-

logist. They can help guarantee patient compliance, but they may also make treatment more time-consuming and may challenge the course of treatment. "Some of them are very demanding. They want you to say things that you are not really comfortable saying. I'll find a problem while examining a patient, and when I try to explain this to the nurse, they don't want to hear it."

The other problem is the addition of 10 to 15 minutes per patient for consultation, Dr. Blonsky said. "All of this time is money, which the insurance companies won't pay for." He added that he thinks physicians should be reimbursed "for the time that's put in for these ad-libbed conferences."

Payment delays are another potential problem in workers' comp cases, Dr. Blonsky said. In his practice, six months is the average, and contested cases can take years to resolve, he noted. "The employer says, 'We don't think it's a legitimate claim, so the workers' comp insurance refuses to pay. But the health insurer says it is a workers' comp case, so it's not going to pay. So here's the patient with no coverage and a physician who has provided treatment without reimbursement and who now sees no chance of reimbursement until quite far down the road.'"

Physicians who have experienced interference in the physician-patient relationship in worker's comp cases may write to the Health Care Finance Division, ISMS, 20 N. Michigan Ave. Suite 700, Chicago, IL 60602. ■

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ISMIE Update

Watch for
coverage of
how to handle
adverse
outcomes

Obstacles on the road to diagnosing MI

Detours from a classical presentation can cause trouble.

BY JANE ZENTMYER

A 38-year-old man with a history of cardiovascular disease presented at the emergency department with substernal chest pain radiating into his arm. His electrocardiogram was normal, and his physician diagnosed reflux esophagitis before discharging him. Later that night the patient died of myocardial infarction. The patient's family sued the physician for failure to diagnose MI and unstable angina, failure to admit the patient and failure to order a cardiology consult. This example, recounted by emergency physician and attorney Daniel Sullivan, MD, illustrates a significant area of litigation.

Myocardial infarction is one of the most commonly litigated conditions involving ISMIE-insured internists and cardiologists, according to data collected by ISMIE's Internal Medicine Risk Management Subcommittee and based on six years of closed lawsuits that resulted in payments. For cardiologists, MI is the most costly condition litigated, resulting in an average payment of \$379,773, and for

internists, MI is the second-most-expensive condition litigated, with an average payout of \$259,249.

With those numbers in hand, ISMIE conducted a seminar on May 31 to address liability related to diagnosing and treating MI. Diagnosis can be difficult because of the absence of symptoms, according to Dr. Sullivan, assistant professor of emergency medicine at Cook County Hospital and chairman of the Department of Emergency Medicine at Ingalls Memorial Hospital. He cited a study in which almost half of the 708 participants who had suffered MIs experienced no symptoms. In the remaining cases, the symptoms were so atypical that neither the patients nor the physicians suspected MI. About 30 percent of the 708 confirmed AMI cases were diagnosed only after the evidence of MI was identified on an EKG.

"The preconception of the typical or the classic presentation may actually be an obstacle to recognizing AMI," Dr. Sullivan said. "There are a lot of cases [in which] because it wasn't a classic description, the

diagnosis was missed." Another study showed that of 104 participants who experienced MI, only 59 percent characterized the chest pain as pressure. In fact, 28 percent described their chest pain as aching, burning, sharp or stabbing.

Physicians also need to be aware that some "bedside maneuvers" could lead to missed diagnoses, he added. A patient's relief from antacids, for example, shouldn't automatically rule out MI as a diagnosis. One study showed that up to 7 percent of patients who suffered confirmed MIs experienced complete relief from antacids, Dr. Sullivan said. EKGs can also be unreliable, with at least one study showing that 3 to 10 percent of MI patients have normal EKGs.

It's important for physicians to consider historical factors that contribute to an MI diagnosis. When doctors take patient histories, they could use a checklist, for example, to help ensure that they get all the necessary information. In addition, educational programs can help doctors learn more about clinical issues related to MI. At the



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Updated medical-legal texts available

The second edition of "The Law of Medical Practice in Illinois," co-written by ISMS Legal Counsel Robert John Kane, is now available.

The two volumes cover malpractice and liability law; malpractice litigation; physician licensure and discipline; the organization of practices, hospitals and managed care organizations; and decision-making in reproductive care and dying.

Published by Lawyers Cooperative Publishing in Rochester, N.Y., the second edition was co-written by Theodore LeBlang, professor of medical jurisprudence and chairman of the Department of Medical Humanities at the Southern Illinois University School of Medicine, and Eugene Basanta, professor of law and associate dean at the SIU School of Law.

The authors stressed that the volumes are not a substitute for competent legal advice.

"The Law of Medical Practice in Illinois" is

a resource for all persons involved in health care delivery. It was designed to assist physicians in meeting the complex and often confusing mandates of the law," Kane explained.

In the forward to the volumes, Illinois Department of Public Health Director John Lumpkin, MD, wrote: "Health care organizations linking hospitals and physicians, as well as new types of physician group arrangements, have come into being. Concerns over cost and quality of care have led to the formation of new ways of financing and delivering care. Moreover, tort reform initiatives and new case law have changed the landscape in malpractice litigation. The in-depth review of legal and regulatory issues makes this book a must for anyone involved in the delivery of health care or the litigation of health care issues."

The texts cost \$275 plus Illinois sales tax and can be ordered by calling (800) 254-5274.

ISMIE seminar, Dan Fintel, MD, associate professor of medicine at Northwestern University Medical School and director of the coronary care unit at Northwestern Memorial Hospital, discussed the formation of blood clots in the early stages of MI. "Just a better understanding of those important processes leads to a more rational approach to therapy to combat the activation of these clotting factors," he said.

The diagnosis and treatment of MI can be complicated by managed care. A physician who decides on extra testing for an HMO enrollee with chest pain must usually get approval from the plan first.

If the plan denies coverage, physicians should follow through. "Advise the patient that [the managed care plan] cannot decide whether he or she gets care," said attorney Martin Bresler, a partner at Chicago-based Bresler, Harvik & Glenn Ltd. He recommended that physicians ask patients to sign a release that details the plan's preapproval process and explains that payment for ser-

vices may be denied or may be contingent on the procedure being completed by a facility under contract with the plan. Patients then indicate their decision: transfer to another facility for treatment, forgo services against medical advice because of the plan's denial of payment or remain with their current physician and facility with the understanding they will pay for the treatment themselves.

If the patient refuses to sign the release, "chart the fact that you offered care to your patient and that your patient chose not to accept the care because of the refusal of the HMO or whatever the circumstance may be," Bresler said. "The duty that you have to your patient is paramount to any consideration by managed health care organizations as to whether they're going to pay the bill. You must always act as an advocate for your patient."

For a free audiotape of the MI seminar, ISMIE policyholders should contact the Risk Management Division at (312) 782-2749 or (800) 782-4767, ext. 1327.

Chicago-area IPA allows patients to steer health care

Doctors direct their course toward high-quality patient care and competitive pricing.

BY TODD SLOANE



Warren Gebert/SIS

Physicians, re



A fast-growing independent practice association in Chicago and its north and northwest suburbs aims to keep physicians in control of health care. The Chicago Area Physicians Association was formed to counteract hospital systems' efforts to control physicians through entities like PHOs and attempts by managed care plans to dictate how and when care is delivered.

"The real question is, Who is going to control health care in the future? Will it be physicians and their patients, or hospital administrators and insurance companies?" said CAPA President James Downey, MD, a pediatrician who practices at Evanston and Glenbrook hospitals.

For now, CAPA, with 145 primary care physicians and 20,000 covered lives, is a typically loose-knit IPA. Its main duty is to obtain managed care contracts for its members, who continue to work in their own practices and to refer patients to their affiliated hospitals. But the IPA's leaders envision its transformation in the next year or two to a full-fledged MSO, with services ranging from patient scheduling and billing to tracking outcomes and contracting directly with employers, thus bypassing insurance middlemen.

CAPA is the product of the merger last January of three smaller IPAs: Evanston Glenbrook Physicians Association in Evanston, Northwestern Internists IPA in Chicago and Northwest Primary Care Network in Arlington Heights. All CAPA's members have some association with the Northwestern Healthcare network, either serving as staff members or admitting patients to Northwestern Memorial Hospital in Chicago, Evanston Hospital, Glenbrook Hospital in Glenview or Northwest Community Hospital in Arlington Heights.

Within the next two months, CAPA is expected to merge with as many as three more IPAs to become one of the most powerful Chicago-area health care forces, Dr. Downey said. The organization would offer more than 250 physicians, referral contracts with several hundred specialists and the clout to negotiate both managed care and fee-for-service contracts that leave most of the care decisions up to physicians.

Its ambitious plans aside, CAPA is still taking baby steps. Even though CAPA has about a half-dozen managed care contracts, it is waiting for several group practice contracts to end before rolling them into larger pacts that cover the entire IPA, said Robin Bales, CAPA's administrative director. Although CAPA is preparing for the day when managed care dominates the Chicago area, about four-fifths of the member physicians' business is fee-for-service.

For most of its members, just belonging to a group of like-minded colleagues in a time of rapid change in health care has strong psychic value, said M. LeRoy Sprang, MD, an Ob/Gyn on the staff of Evanston and Glenbrook hospitals and chairman of the ISMS Board of Trustees. "The idea is that physicians should be able to bond together and speak with one voice, to remain captain of the [health care] ship," Dr. Sprang said.

For physicians affiliated with an organization like Northwestern Healthcare, the need for collective action is becoming more apparent. In the past few years, the network of hospitals and clinics has purchased the practices of primary care physicians and specialists as part of its effort to form a vertically integrated health care network.

Such hospital control of physicians is especially troubling given the need for physicians to succeed under managed care contracts, said Douglas Cleary,

MD, president of Northwestern Internists IPA. For doctors looking at taking on risk, there's a concern about the role you have in governance of what is essentially a wholly owned subsidiary [of Northwestern Healthcare]. The value for us of [CAPA] is creating competition for referrals and the ability to attract a more varied patient base and, ultimately, to have group purchasing of goods and services."

Dr. Downey said that while the success of integrated delivery systems is open to debate, "there is no reason for hospitals to be at the top of that pyramid. Hospitals are essentially high-priced hotels; they don't necessarily provide other services with the highest quality or the best price."

In fact, the close association of many of the physicians with their current hospitals could change as CAPA moves toward becoming an MSO, Dr. Downey said. "We already have a number of doctors with affiliations at other hospitals. It is entirely possible we will admit patients to any number of hospitals, depending

(Continued on page 10)

*Hospitals are essentially
high-priced hotels;
they don't necessarily
provide other services
with the highest quality
or the best price.*

Chicago-area IPA

(Continued from page 9)

on the quality and cost of services."

Despite that statement, Northwest Primary Care Network will remain closely tied to Northwest Community Hospital, said Ronald Boduch, MD, a pediatrician who heads the network and serves as a member of the CAPA Board of Directors. NPCN members are part of the hospital's PHO and CAPA. "The advantage for us of being part of CAPA is getting in on the managed care contracts, being able to refer to other doctors across the Chicago area and the centralization of back-office

operations," he said.

It is uncertain whether his network will remain part of the PHO as CAPA becomes more organized, but it will continue to admit patients to Northwest Community, Dr. Boduch said.

Another decision that will have to be made is whether to continue to add Ob/Gyns to CAPA as full members instead of as part of a referral network. Some of the founding members of the Evanston-Glenbrook group are Ob/Gyns. One such example is David Cromer, MD, a CAPA member and chairman of the department of obstetrics and gynecology at Evanston and Glenbrook hospitals.

Not surprisingly, Dr. Cromer argued for the inclusion of Ob/Gyns in the definition of a primary care physician: "Most women between the ages of 18 and 55 think of their Ob/Gyns as their primary care physician," he said. In addition, Illinois has legislation allowing women to designate Ob/Gyns as their principal health care providers, whom they can access without referral or prior approval. "Practically, this means that any physician group that wants to succeed under managed care must have some access to an Ob/Gyn," Dr. Cromer said.

So far, CAPA's staff is minimal, just a half-dozen employees in its Evanston

headquarters. When the group brings its computerization in-house, its staff will increase significantly, Bales said. CAPA hopes to achieve savings through mass-buying of other equipment, for which it will need purchasing experts, he said.

Dr. Cleary said CAPA's more immediate goal is to find a single vendor for all outpatient lab tests, preferably one that will work on a "subcapitated" basis, meaning providing lab services for a set fee per month. The Evanston-Glenbrook group already contracts with one vendor for vaccinations, but so far no purchasing is done for the entire IPA.

Most CAPA members are internists, family physicians and pediatricians. Such primary care doctors are key to winning managed care contracts, Bales said. HMOs and PPOs seek provider groups that can deliver quality preventive care while keeping costs in line. Toward that end, CAPA emphasizes quality assurance.

~

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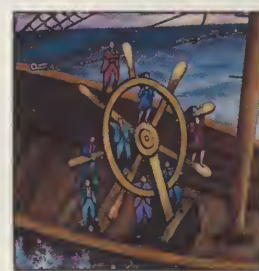
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*We have to train
patients to use primary
care physicians where
that's appropriate.*



That responsibility is overseen by Medical Director Harry Jaffe, MD, who is also assistant chief of internal medicine at Evanston Hospital. "Most well-trained primary care doctors can take care of 90 percent of what comes through their door," he said. "But we have patients who demand to see a dermatologist for a simple rash. We have to train patients to use primary care physicians where that's appropriate. But we have to be careful about managed care. We have to ensure we are continuing to deliver first-rate care to our patients."

CAPA relies heavily on physicians' judgment about referrals. "Ninety percent of requests that come our way [for referrals], we approve," Dr. Jaffe said.

To help ensure that cost control is balanced by quality of care, CAPA is developing a series of care protocols that standardize treatment for given conditions. "To date, we have developed only a few critical pathways, for congestive heart failure and pneumonia. We will do more," Dr. Jaffe said.

To complete its critical pathways program, CAPA wants to develop a patient outcomes database, but such data comes at a high cost, Dr. Downey noted. The kind of management information system that CAPA needs would cost millions of dollars. For that, the IPA needs outside capital.

"If we move to an MSO, we will need significant outside capital, probably bank financing, both for additional staff and data systems," Dr. Downey said. "We are still sorting out where we want to go and what we want to be."

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This information, published as space permits, is reprinted from the Illinois Department of Professional Regulation's monthly disciplinary report. IDPR is solely responsible for its content.

April

Richard C. Berglund, Barrington – physician and surgeon license placed on probation for one year for failing to provide adequate follow-up care to a patient who developed prostate cancer.

Eugene Borzsonyi, Chicago – physician and surgeon and controlled substance licenses revoked for selling large quantities of controlled substances to Department of Professional Regulation and Cook County sheriff investigators.

Jorge Olmos-Carranza, Chicago – controlled substance license probation extended for one additional year for violating a previously ordered probation by prescribing Ritalin to a patient.

Alexander Delgadillo, Batavia – physician and surgeon license reprimanded and fined \$1,000 for not keeping a proper controlled substance log.

Ralph W. Everson, Loves Park – physician and surgeon license placed on indefinite probation and controlled substance license indefinitely suspended due to relapse of chemical dependency.

Eliana Gaviria, Oak Brook – physician and surgeon license indefinitely suspended due to failure to file Illinois income tax returns for the years 1990 through 1994.

Kimberley A. Hollender, Decatur – controlled substance license issued and placed on probation until July 1, 2002, due to history of depression.

Archibald Hutchinson, Ottawa – physician and surgeon license placed on indefinite probation for engaging in a sexual relationship with a patient.

Dong Sun Kim, Skokie – physician and surgeon license reprimanded and fined \$1,000 for failing to complete the required number of remedial education hours in violation of a previously ordered departmental probation.

Melvin Norman Seglin, Evanston – physician and surgeon license reprimanded and placed on probation for one year due to felony conviction.

Allen M. Siegel, Chicago – physician and surgeon license placed on probation until September 30, 1999, for unprofessional conduct in the treatment of a mental health patient.

Lynn T. Shepler, Falmouth, Mass. – physician and surgeon license indefinitely suspended after failing to comply with the terms and conditions of a previously ordered probation.

Erik Tanck, Chicago – physician and surgeon license placed on probation for five years for allegedly diverting a controlled substance for his own use.

Marvin E. Tazelarr, Lombard – chiropractor license indefinitely suspended after failing to comply with the terms and conditions of a previously ordered probation.

May

Steven P. Brasch, Chicago – physician and surgeon license placed on probation for one year after failing to properly respond to a drug overdose that occurred in his home.

Thomas Chua, Aurora – physician and surgeon license reprimanded and fined \$500 due to overbilling for a medical procedure.

Edward L. Colloton, Bloomington – physician and surgeon license reprimanded for engaging in misleading advertising practices and ordered to

cease and desist from any advertising that references the Excimer laser.

Winit Dejsahrai, Downers Grove – controlled substance license restored on probation for two years.

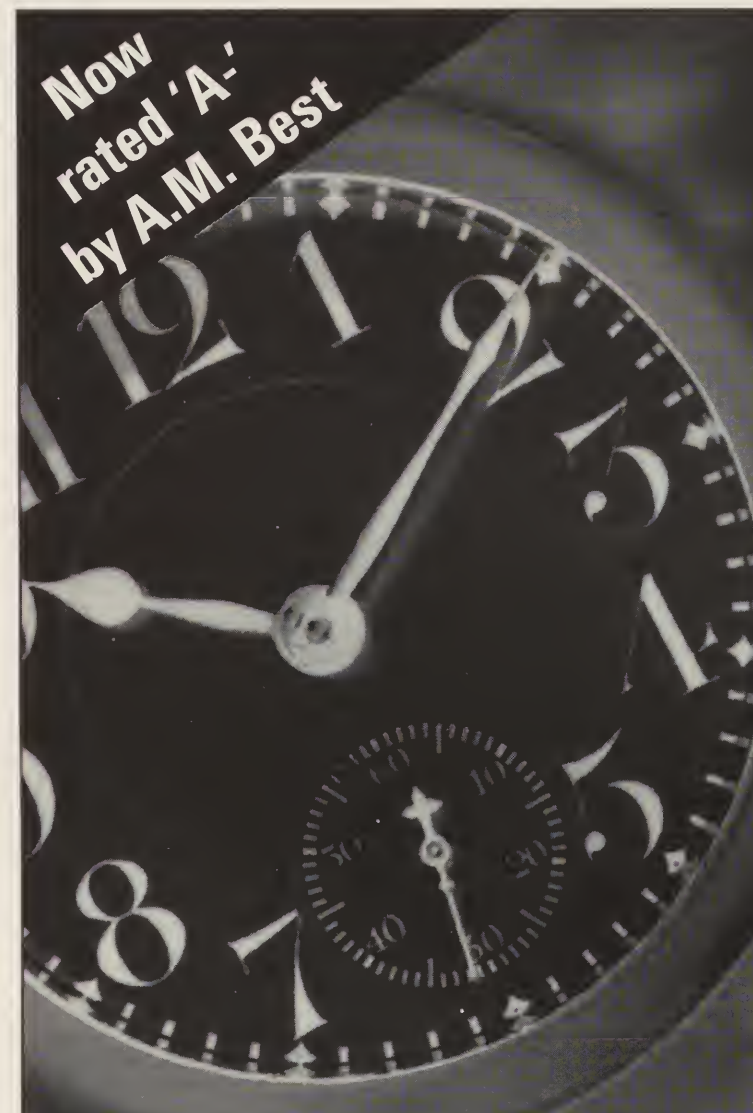
Ward Dunseth, Carlinville – physician and surgeon license placed on probation for one year for committing gross negligence when he failed to properly treat breast cancer, which necessitated a second surgery.

Robert G. Hickerson Jr., Knoxville – physician and surgeon license reprimanded and fined \$2,000 for failing to keep an

accurate inventory and controlled substance log on the samples dispensed from his office in the last two years.

Wilbur Eugene Johnson, Rode Falls – physician and surgeon license suspended for six months followed by probation for five years for violating the terms and conditions of a previously ordered probation.

Robert J. Lee, Evergreen Park – physician and surgeon license indefinitely suspended due to opioid and benzodiazepine dependency and cognitive impairment.



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State high court

(Continued from page 1)

briefs in the current case while it has accepted briefs from several organizations that have echoed many of the emotional yet faulty arguments made by the opponents. This is a highly unusual practice for any court, and we don't understand it."

ISMS President Jane Jackman, MD, told news conference attendees that legal arguments in amicus briefs may factor heavily in decisions made by justices. She cited the U.S. Supreme Court's recent ruling striking down physician-assisted suicide, which included language almost identical to wording in the brief submitted by the AMA. "This is something that just happened, and it shows the impact that amicus briefs can have on a Supreme Court decision."

The court permitted three joint amicus curiae briefs to be filed by six tort reform

opponents: the Illinois NOW Legal and Education Fund and the Breast Implant Information Exchange; the Brotherhood of Heat and Frost Insulators, Local 17, and the Southeast Environmental Task Force; and the National Association for the Advancement of Colored People and the Cook County Bar Association.

The need for amici from all interested parties is especially critical given the court's decision to make the Best case the vehicle for its ruling on the constitutionality of the entire law, said ICJL members at the news conference. "This case is a product liability case that has nothing to do with medical malpractice, yet the [trial court] judge struck down those [medical malpractice] provisions," said Mark Deaton, senior vice president and general counsel for the Illinois Hospital and HealthSystems Association. "The parties in the case have absolutely no interest in the medical malpractice provi-

sions. In instances like that in the past, the Supreme Court has allowed us to file amicus briefs to discuss those issues."

"The danger of this case is that you have a very, very narrow set of facts that may result in a broad, sweeping decision that throws out sections of the tort reform amendments of 1995 that are not at issue in this case," said Mark Killion, general counsel for the Illinois Manufacturers' Association. Since 1994, the IMA has asked the Supreme Court for permission to file an amicus brief 18 times. The organization was denied only twice, with the second time being the request related to the 1995 tort reforms.

The three briefs that were filed dealt with specific issues that were raised during the legislative debate in 1995, Killion said. For example, one brief argued that the tort reform law would discriminate against women, and another argued that it would discriminate against minorities.

"Our position is that we would have liked that same opportunity – for the hospitals to focus on its issues, the medical society to focus on its issues, and others to focus on the business climate issues," Killion said.

Newspaper ads stating ICJL's concern about the unfairness of the legal process on this issue were published in the Belleville News-Democrat, the Southern Illinoisan in Carbondale, the Chicago Sun-Times, the Peoria Journal Star, the Rockford Register Star and the State Journal-Register in Springfield. Murnane said ICJL remains optimistic that the justices haven't made up their minds on tort reform.

"We hope the court will recognize the value of the good, sound legal arguments to be made for tort reform – and for the prerogative of the General Assembly to establish public policy," Murnane said. ■

State merges

(Continued from page 1)

invested in prevention programs, particularly for children, Patla said.

For physicians who treat Medicaid recipients, the reorganization of human services may not directly affect their practice. "My sense is that this is not going to have that much impact on day-to-day activities of a doctor except that a doctor's patient will have easier access to a range of services beyond strictly medical services," said Daniel Luchins, MD, associate director for clinical services in the former IDMHDD. "There are things that doctors themselves don't do but that clearly are essential for a patient's physical well-being."

IDHS is planning to offer a toll-free telephone number to inform callers about the new department and its services, Patla said. That doesn't mean that everything will be up for grabs, though. "The well-established patterns that people are familiar with are not going to be thrown out the window just because there is a new department," she noted. "In fact, if they're used to dealing with their local public health department, they may not even notice that there is a new Department of Human Services that actually gives funds to that local health department."

Some programs and departments that interact with physicians haven't changed. IDPH, for example, has kept its regulatory authority of hospitals and nursing homes, Patla said. In addition, the Illinois Department of Professional Regulation will remain separate. Although IDHS will now administer the eligibility portion of Medicaid, IDPA will continue to manage the medical assessment program and the proposal to move Medicaid enrollees into mandatory managed care through MediPlan Plus. ■



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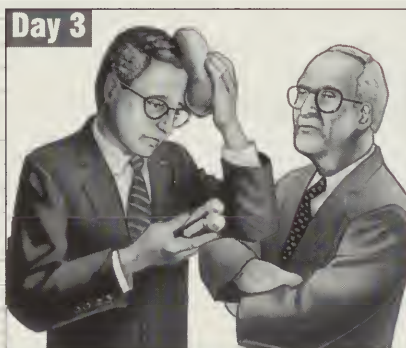
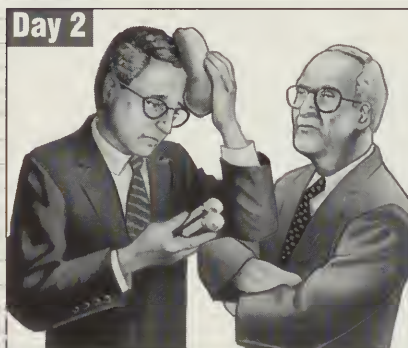
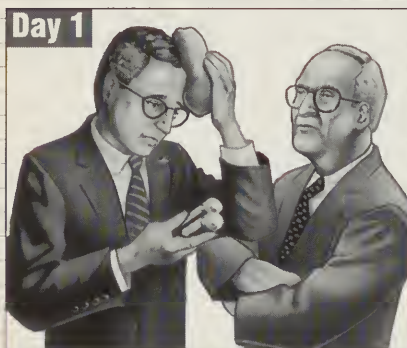
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HCFA proposes

(Continued from page 1)

HCFA. "Data and methods need to be developed to compare proposed methodology with physicians' actual expenses."

The proposed practice expense relative values would increase the most for dermatology, with an 18 percent hike; rheumatology, 15 percent; family practice, 12 percent; hematology oncology, 11 percent; and radiation oncology, 10 percent. The greatest reductions would be for gastroenterology, 20 percent; cardiology and vascular surgery, 17 percent; nephrology, 13 percent; and ophthalmology and orthopedic surgery, 11 percent.

The practice expense values account for about 41 percent of the total Medicare physician payment. The value associated with work accounts for another 45 percent of the Medicare formula, according to an ISMS analyst. The remaining 4 or 5 percent relates to malpractice expenses.

These three expense areas – practice, work and malpractice – are also adjusted by the Geographic Practice Cost Indices to reflect the variations in operating costs in each Medicare fee area compared with the national average. Federal law requires HCFA to review and, if necessary, adjust GPCIs at least every three years.

In the 1995 update, several Illinois areas lost significantly, but the proposed 1998 update would put three Illinois areas in the seven regions with the highest increases nationally. Those Illinois areas are Cook County, the East St. Louis area and the rest of Downstate Illinois. The collar counties would be the only area in Illinois to experience a small reduction, according to the ISMS analysis.

In addition, the conversion factor, which transforms the relative value of a service into the actual dollar amount Medicare will pay, might be revised. Current federal law sets three conversion factors, and HCFA's 1998 proposal would increase primary care services by 7.9 percent, surgical services by 2.9 percent and all other services by 2.3 percent. But pending federal legislation seeks one conversion factor. A proposal from President Bill Clinton would reduce payments for primary care services by 3.8 percent and surgical services by 11.9 percent.

"Until now, the practice expense discussion has been debated as an isolated issue," Dr. Dickey wrote. "At the same time, both sides of the aisle in Congress and the administration have proposed immediate implementation of a single conversion factor. The combination of practice expense changes and a lower conversion factor could drive Medicare payments below Medicaid rates. Serious disruptions and access problems may occur if policymakers impose drastic payment cuts."

Although there have been proposals for either a transition period allowing physicians time to adjust to the possible lower payments or a delay in implementing the changes to provide more debate, these suggestions require action from Congress. The issue is pending as part of the budget reconciliation act. Until the debate is concluded, physicians should evaluate their patient base and services to try to anticipate the impact that changes might have on their income, Dr. Schneider said.

"One of the challenges for physicians in being able to anticipate the effect is that physicians' practices are a mixture

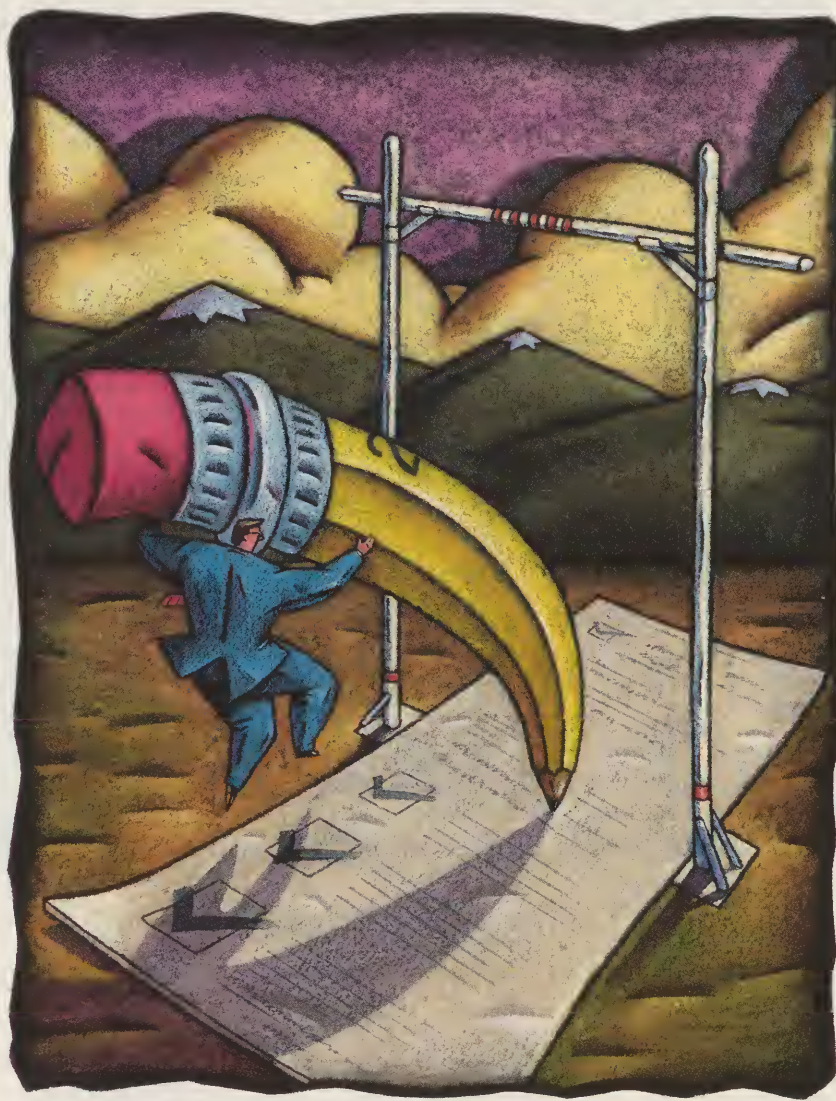
of patients – Medicaid, Medicare, commercially insured contracted outpatients," Dr. Schneider said. The reduction in Medicare surgical fees might lead some to say that surgeons will be hit hard, but surgeons do more than just operate, and they treat more than just Medicare patients, he explained. They may act as consultants or perform patient assessments, for example. "Although one likes to focus on what is going to happen to individual services, it's difficult to know what's going to happen to you unless you know the entire breakout of [services in] your practice." ■

GAIL ROSSEAU, MD, explains image-guided surgery during a demonstration of a new cybersurgical tool at the Chicago Institute of Neurosurgery and Neuroresearch. The demonstration was part of a neuromedicine program hosted by reporter Bill Kurtis and neurosurgeon Leonard Cerullo, MD.



Andrew Corrigan Halberm

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Why physicians,
legislators should
become partners

PAGE 7

Illinois Medicine

ILLINOIS STATE MEDICAL SOCIETY • AUGUST 1 1997

How to handle adverse outcomes

PAGE 6

Governor signs ISMS-supported bills

ADVOCACY: Genetic test result confidentiality and lower blood alcohol level now law in Illinois. BY JANE ZENTMYER

[SPRINGFIELD] ISMS-supported bills that passed the General Assembly landed on Gov. Jim Edgar's desk. Some were still waiting for his consideration as this issue of Illinois Medicine went to press, while others have already been signed into law. The governor has acted on the following ISMS-backed bills:

LOWER BLOOD ALCOHOL LEVEL

After a nine-year battle, Illinois lowered the limit for drivers' legal blood alcohol content to .08 from .10. Gov. Jim Edgar signed S.B. 8 into law on July 2 – just in time for the Independence Day weekend. "The legislation I'm signing today will

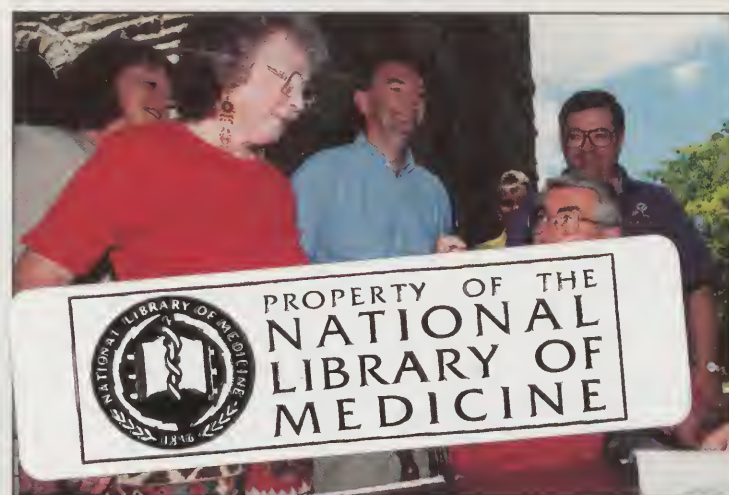
make Illinois streets and highways safer for everyone," Edgar said. "The .08 law is in effect for 14 other states and has led to a significant reduction in alcohol-related traffic accidents in those states."

The law's lead sponsors were Sen. Christine Radogno (R-LaGrange) and Rep. Thomas Johnson (R-West Chicago). Several studies have shown that states with a .08 limit have recorded 18 percent fewer traffic crashes involving drivers with a blood alcohol level of more than .15, said Secretary of State George Ryan, a strong supporter of the legislation. In Oregon, for example, alcohol-related crashes decreased almost 11 percent just one year after enactment of a similar law.

"I'm convinced that the tide turned for .08 when we were

able to convince legislators and the public that .08 does not target social drinkers, people who stop after work for a couple of beers with friends," Ryan said. "This new law, like all [driving under the influence] laws on the books, targets drivers who are impaired when they get behind the wheel of a car and can't drive safely." To reach .08, a 160-pound man would have to consume four drinks in one hour, and a 137-pound woman, three drinks per hour, Ryan said. The state defines a drink as 12 ounces of beer, 5 ounces of wine or 1 ounce of liquor.

Ryan thanked ISMS for its support of the legislation. "As your secretary of state and as a concerned citizen, I share your views in lowering the illegal blood alcohol content to .08," he wrote in a letter to ISMS.



EDGAR SIGNS the ban on genetic discrimination into law on June 23 in Galesburg. Looking on are (left to right) Knoxville resident Carolyn Dean, whose concerns led to the development of the bill, Hawkinson and Moffitt.

"Statistics, scientific studies and real-life experiences support the need for .08 in Illinois."

GENETIC DISCRIMINATION BAN

On June 23, the governor signed H.B. 8, which prohibits employers and insurance companies from using genetic information test results to discrimi-

nate against employees or beneficiaries. Galesburg Republicans Rep. Don Moffitt and Sen. Carl Hawkinson sponsored the bill.

"Advances in genetic testing enable more and more people to assess their individual risk of developing serious illnesses and to take preventive action as a

(Continued on page 11)

INSIDE

Asian tiger
mosquitoes
on the
prowl



PAGE 3

Have we
lost the war
on cancer?



PAGE 5

DEPARTMENTS

Malpractice
Roundup.....6

Classifieds9

AMA, ISMS annual meetings deal with partial-birth abortion

POSITIONS: Delegates debate state and federal legislation. BY LYNN KOSLOWSKY

[CHICAGO] Since debate at the AMA and ISMS annual meetings stems from issues on the minds of physicians, it's no surprise that some of the same issues arise at both meetings. This year, one such issue was partial-birth abortion, or intact dilatation and extraction (intact D&X), which has ethical and practical implications for physicians and has been the subject of state and federal legislation. On June 25, AMA delegates debated several resolutions and a report submitted by the AMA's Board of Trustees.

ISMS played a key role in bringing the D&X issue to the AMA's last interim meeting and contributing to an AMA study. At a meeting last November, ISMS' Board of Trustees approved a resolution urging the AMA to "immediately and diligently" oppose all intact D&X procedures and to establish



Edward Fesco, MD

AMA policy reflecting that action.

Then, at the AMA's interim meeting, the Illinois resolution was debated, and delegates voted to conduct a study. ISMS provided input into that study and the subsequent report, which does the following:

- Reaffirms current AMA policy stating that early termination of pregnancy is a medical procedure

(Continued on page 8)

Illinois resolutions fare well at AMA meeting

Resolutions submitted by the Illinois delegation did well at the AMA House of Delegates annual meeting held June 22-26. Of the 15 resolutions submitted by the delegation, only two were not adopted. The other 13 resolutions were adopted in their entirety, rewritten so that their intent was incorporated into substitute resolutions or included in reports, or adopted as reaffirmations of existing AMA policies. Chairman of the Illinois delegation Edward Fesco, MD, said the group "discussed things and came to a consensus. As a unit, we worked together very well and had very few problems."

One substitute resolution that was adopted calls for the AMA to work on removing

the restrictions that prevent people from buying medical savings accounts. It also asks the AMA, specialty societies, state medical associations and county medical societies to develop educational materials to help consumers select MSAs. This substitute resolution is similar to a resolution approved by the ISMS House of Delegates in April.

Another Illinois resolution asked the AMA to oppose federal legislation that would create new mandates or entitlements to fund health care services for uninsured children. Although the resolution wasn't adopted as presented, its intent was incorporated into a related report submitted by the AMA Council on

(Continued on page 8)

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Tort reform cited for aiding economy

ANALYSIS: Stabilization of litigation costs was one reason the state law was passed. BY JANE ZENTMYER

[CHICAGO] Illinois legislators and their constituents were behind the 1995 tort reform law because they wanted to reduce excessive litigation and the high costs associated with it. Consider the victim of a minor stroke who is now suing the Safeway supermarket chain and the Dairy Farmers of Washington. The plaintiff, who said, "I think milk is just as dangerous as tobacco," wants warning labels about fat and cholesterol levels

placed on dairy products and in all dairy industry ads and commercials. He is also seeking reimbursement for his medical expenses and personal injury.

The Legislature passed H.B. 20, the tort reform bill, because fear of lawsuits was curbing business development and increasing costs to consumers, said one of the bill's sponsors, Rep. Tom Cross (R-Yorkville). "We've almost become frozen in our ability to try different

things, not only from a medical standpoint, but also from a business standpoint and a pharmaceutical standpoint. The whole process of tort reform was to try to bring us back into some sense of reasonableness that we've lost."

Now that the 1995 tort reform package is being deliberated by the seven-member Illinois Supreme Court, it's worthwhile to recall why the law passed, why ISMS supported it and why ISMS

was preparing an amicus brief as this issue went to press.

A critical element of the law is a \$500,000 cap on noneconomic damages. The cap allows those injured to receive compensation for quantifiable damages, such as lost wages and medical expenses but prevents large damage awards for items that are difficult to quantify, such as pain and suffering. "No one who was involved in tort reform and is a proponent said that you shouldn't be compensated if you were unjustly hurt," Cross said. "That's not the issue. It's the extreme verdicts that didn't make sense."

The Legislature was the appropriate place for tort reform to be developed, debated and legislated, according to Illinois Attorney General Jim Ryan. In an amicus brief he submitted to the court, he wrote, "In determining a statute's constitutionality, this court has said time and time again that it will not do what the plaintiffs are asking here: It will not decide whether legislation is wise, necessary or the best means of attacking a problem."

A primary problem that had to be attacked was cost. ISMS President Jane Jackman, MD, said, "Physicians helped raise the consciousness of the people of Illinois as to how malpractice costs affected them. It affected them the most directly through their pocketbooks."

Medical malpractice costs are staggering. In 1980, the total indemnity paid on 243 closed claims in Illinois was about \$11 million, according to a 1994 study released by the Illinois Department of Insurance a few months before tort reform was enacted. In 1992, the total indemnity paid on 703 closed claims stood at nearly \$279 million, and for the 12-year period of 1980-92, the total indemnity on closed claims was \$1.6 billion.

The DOI has not yet released an updated version of the medical malpractice claims study, according to a spokesperson. But earlier this year the Illinois Civil Justice League, a coalition of organizations supporting tort reform, surveyed the nine circuit courts that account for about 75 percent of all civil filings in Illinois. The survey showed that the number of civil suits filed dropped by about 30 percent between 1994 and 1996 — the full years before and after tort reform's enactment. Edward Mur-nane, ICJL's president, said the figures were "a clear indication that tort reform is meeting one of its objectives."

The Coalition for Consumer Rights, a group that has connections to the plaintiff bar, attacked ICJL's findings in July, citing its own contradictory conclusions, which it said were based on data from DOI. But insurance department spokesperson Nan Nases said the agency believes the coalition's figures were derived from DOI market share reports, which are directly based on insurance companies' annual statements, and not from a DOI survey. "However, the department has not performed its own analysis of the market share data and cannot comment on the methodology or assumptions used by the coalition," she said.

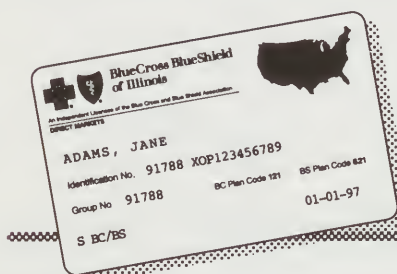
Tort reform has been good for the state, according to Brian Timpone, spokesperson for House Republican Leader Lee Daniels (R-Elmhurst), another sponsor of H.B. 20. "Our economy is booming. I'm not going to say that it's all because of tort reform, but it is certainly an issue that big corporations as well as small businesses look at when setting up here in Illinois."



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IDPH takes a swat at Asian tiger mosquitoes

PUBLIC HEALTH: Local health departments get grants for surveillance and control. BY DON PHILLIPS

[SPRINGFIELD] Asian tigers may be an endangered species, but Asian tiger mosquitoes are not. Because of heavy spring rains, the Illinois Department of Public Health is anticipating a larger-than-usual mosquito outbreak this summer and fall and awarded \$246,442 in grants to 22 local health departments for surveillance and control of Asian tiger mosquitoes and other container-breeding mosquitoes.

The Asian tiger mosquito, which is believed to have arrived in the United States in 1985 in used tires shipped from Japan, is an aggressive daytime-biting mosquito that breeds in containers holding water, such as tires, cans and yard ornaments, according to IDPH spokesperson Tom Schafer.

"The grants will help local health departments develop and administer vector control programs that will be used to evaluate the threat to the public's health from viruses carried by mosquitoes," said IDPH Director John Lumpkin, MD.

Schafer said grant decisions were based on the presence of Asian tiger mosquitoes in an area, the number of used-tire sites, the number of cases of past mosquito-borne California encephalitis and the proximity of large mosquito populations to large population clusters. Asian tiger mosquitoes have been identified in 14 of the state's 102 counties: Alexander, Cook, Jackson, Jasper, Jefferson, Kankakee, Macoupin, Madison, Massac, Pulaski, Randolph, St. Clair, Union and Williamson counties. Schafer said that this type of mosquito was found in 14 counties last year, many of which are also in this year's count.

The largest awards went to the Chicago Department of Public Health, which received \$60,000; the East Side Health District in the East St. Louis area, \$25,000; and the Southern Seven Health Department, covering the seven southernmost counties, \$20,900. Grants of at least \$8,000 were awarded to health departments in Jasper, Jo Daviess, Kankakee, LaSalle, St. Clair, Stephenson, Tazewell and Woodford counties, as well as the Egyptian Health Department and the Peoria City/County Health Department.

Schafer said the grants will be used to identify sites where tires have been stored or discarded and to sample mosquitoes found in the tires for viruses. The funds will also pay for the cleanup of some of the tire sites, as well as legal action, if necessary, to enforce the cleanups. Money for the grants comes from the department's share of the state's Used-Tire Management Fund. The fund

is generated by a \$1 fee for each new tire sold in Illinois, according to IDPH.

The Asian tiger mosquito has been found to carry viruses that can be transmitted to humans. But there are no documented cases of transmission to a human in the continental United States. Nonetheless, public health officials are concerned about the Asian tiger mosquito because of its aggressive nature. ■

Former ISMS President Raymond E. Hoffmann, MD, dies



Former ISMS President Raymond E. Hoffmann, MD, died suddenly on July 23, as this issue was going to press. Dr. Hoffmann, a general surgeon from Rockford, was a member of the ISMIE Board of Governors and the ISMS Board of Trustees. He served as 1992 speaker of the ISMS House of Delegates, a term characterized by his sense of humor and ability to think on his feet. His belief that "medicine is the best profession there is" formed the theme of his 1995 presidency. See the Aug. 15 issue for more coverage.



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REPORT for Illinois Physicians

MEDICARE

MAGNETIC RESONANCE ANGIOGRAPHY - COVERAGE

Magnetic resonance angiography (MRA) is an application of magnetic resonance imaging (MRI) that provides visualization of blood flow, as well as images of normal and diseased blood vessels. While MRA appears to be a rapidly developing technology, the clinical safety and effectiveness of this procedure for all anatomical regions have not been proven. As a result, Medicare will provide coverage for MRA on a limited basis. Below are the only indications for which Medicare coverage is allowed for MRA. All other uses of MRA will not be covered.

- A. **Head and Neck.**—Studies have proven that MRA is effective for evaluating flow in internal carotid vessels which are located in the head and neck. Present scientific evidence reveals that MRA after a positive ultrasonography may be used as an appropriate preoperative diagnostic test for patients with symptoms of carotid stenosis. MRA may be covered when it is performed on patients with symptoms associated with carotid stenosis for which surgery may be found to be appropriate based on the results of these tests.
- B. **Peripheral Vessels of Lower Extremities.**—Studies have proven that MRA of peripheral vessels is useful in determining the presence and extent of peripheral vascular disease in lower extremities. This procedure is non-invasive and has been shown to find occult vessels in some patients, for which those vessels were not apparent when contrast angiography (CA) was performed. Medicare will cover either MRA or CA to evaluate peripheral vessels of the lower extremities. However, both MRA and CA may be useful in some cases, such as:
 1. A patient has had CA and this test was unable to identify a viable run-off vessel for bypass. In addition, exploratory surgery is not believed to be a reasonable medical course of action for this patient.
 2. A patient has had MRA, but the results are inconclusive.

It should be noted that physicians may choose either contrast angiography (CA) or MRA as diagnostic tests after a positive ultrasound for their patients. MRA is not performed routinely as an adjunct to CA. CA furnished in addition to MRA might be appropriate only when the results from the MRA and the ultrasound are incongruent or inconclusive.

While the intent of this policy is to provide reimbursement for either MRA or CA, Medicare is also allowing flexibility for physicians to make appropriate decisions concerning the use of these tests based on the needs of individual patients. It anticipates, however, low utilization of the combined use of MRA and CA. As a result, it encourages contractors to monitor the use of these tests and, where indicated, requires evidence of the need to perform both MRA and CA.

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EDITORIAL

So long, Joe Camel

Author Joyce Carol Oates wrote that a personal perspective is the only kind of history that exists. The \$360 billion proposed settlement between tobacco manufacturers and attorneys general from 40 states, including Illinois, is being called historic, but reactions to it seem to be based on perspective.

One of the more colorful characterizations came from the Florida attorney general, as reported in the Chicago Tribune: "The Marlboro man will be riding into the sunset on Joe Camel."

The American Lung Association was less sanguine, refusing to sign off on the agreement primarily because of the pact's handling of the Food and Drug Administration's authority in regulating nicotine. Before the FDA could begin eliminating nicotine in the year 2009, it would have to prove that the removal wouldn't increase black market sales of unregulated or higher-nicotine products. That would be tough to prove, critics say.

Some other health organizations and coalitions see some value in the settlement. The Campaign for Tobacco-Free Kids said the public health benefits outweigh the liabilities. Others are adopting a wait-and-see stance. The AMA has appointed a task force to evaluate the proposal and send recommendations to the AMA's Board of Trustees.

In April 1996, ISMS' House of Delegates directed the Society to support the attorney general's decision about joining the lawsuit against tobacco companies

and to support assessments of the public health care costs of smoking and apportion that cost to cigarette taxes. The Society also backs bans on cigarette advertisements and advocates programs communicating the risks of tobacco to all Illinoisans, especially young people.

The proposed settlement would ban billboard and other outdoor advertising and the use of human and cartoon characters in ads. It would also subject the tobacco industry to fines if youth smoking didn't decrease sufficiently.

Illinois Attorney General Jim Ryan said that when he filed suit last November, he had three goals: to stop cigarette companies from marketing to children, to require the industry to tell consumers the whole truth about tobacco and to reimburse Illinois taxpayers the billions of dollars paid to cover the cost of tobacco-related illnesses. He said he believes that the proposed agreement would achieve those objectives and more, and that Illinois stands to gain far more than if the case had been taken to trial. Illinois has incurred costs of more than \$2 billion for the treatment of smoking-related illness, and Ryan said he's confident the state would eventually receive substantially more than what it has spent. Millions would be earmarked for children's health care.

It remains to be seen whether Congress and the president will sign off on the settlement and if so, whether the public health benefits realized will match expectations.

PRESIDENT'S LETTER

Physician-assisted suicide is not patient advocacy

Jane L. Jackman, MD



The medical profession needs to do a better job of educating patients about what can be achieved with modern pain management.

"The movement for legally sanctioning physician-assisted suicide is not a victory for personal rights. It is a sign of society's failure to address the complex issues raised at the end of life."

— Lonnie Bristow, MD, immediate past president, AMA

A sigh of relief sounded from the medical community recently when the U.S. Supreme Court ruled that there is no guaranteed right to physician-assisted suicide under the U.S. Constitution. This ruling does not settle the matter, however, since states will be allowed to enact their own laws. In Illinois, everyone, not just doctors, is prohibited from helping people commit suicide.

The AMA, along with 40 other organizations including ISMS, submitted an amicus brief to the U.S. Supreme Court, arguing that the doctor's traditional role in society is that of healer and comforter, not that of executioner, and that merging the two roles would be inappropriate and would damage the doctor-patient relationship. Chief Justice Rehnquist agreed with this viewpoint and in fact quoted almost directly from the AMA's brief when he explained the court's ruling.

Although I expect most of you were as pleased with the ruling as I was, I am disturbed that public opinion polls tell us that most Americans are in favor of physician-assisted suicide, at least for patients facing terminal, painful illnesses. What that tells me is that the public has lost its confidence in our profession's ability to help them achieve a peaceful death in a hospital setting. They are fascinated by modern medical technology (some may even have convinced themselves that death is optional), but they do not approve of the way it is often used in end-of-life care. When treating patients in the final stages of incurable illness, what is feared most is intolerable pain, followed by loss of dignity and dependence on others.

We have made great strides in pain management, and most communities have access to good hospice care. Why is suicide thought

by many to be the best way to achieve "death with dignity"? I suspect that many physicians, including myself, could benefit from a refresher course in pain management and the psychological issues in end-of-life care. But I also believe that the medical profession needs to do a better job of educating patients about what can be achieved with modern pain management.

The majority of hospice care in the United States occurs only in the last two weeks of life, but it would be more effective at a much earlier stage. This would suggest either that patients do not realize the effectiveness of hospice care or that their physicians aren't recommending it at the appropriate time.

I can remember when most patients died at home surrounded by loved ones and when death was considered as much a natural part of life as birth. Over the last 25 years, it has become more the norm to die in hospitals, surrounded by strangers and a lot of unwanted technology. Patients and their families often have such unrealistic expectations about what modern medicine can do that discussions about advance directives and dying are difficult. Yet we have a responsibility to discuss these issues with our patients, preferably before such a discussion becomes necessary.

Doctors need to stay in the healing business and not cross the line to assisted suicide. In the Netherlands, where this is tolerated, we have seen how easy it is to progress from physician-assisted suicide for the mentally competent but terminal patient to frank euthanasia for the mentally incompetent but sometimes nonterminal patient. Yet if we are to hold fast to our traditional ethics in this matter, we need to give our patients a better option than suicide. We need to educate patients about hospice care and modern pain management. Advance directives should be discussed with all patients, not just the elderly and the critically ill. Even when we cannot cure our patients, we can still function as their best advocates.

GUEST EDITORIAL

More battles lie ahead in the war on cancer

By Samuel Hellman, MD

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Are we losing the war on cancer? Dr. John Bailar, a colleague at the University of Chicago and perhaps the world's leading authority on cancer mortality trends, argues that far from winning it, we are barely holding our own.

Just last week he published a paper showing that the cancer mortality rate hasn't changed much since 1970, the year before the federal government declared war on the dreaded disease.

What is encouraging in his paper, though, is the information that these rates appear to be finally coming down.

According to his work, they dropped 1 percent from 1991 to 1994 – not an astonishing decrease but one that many experts hope represents a real shift.

Another researcher, Dr. Philip Cole at the University of Alabama, reporting on similar data, estimates the drop from 1991 to 1995 to be almost 4 percent, with an additional 1 percent in preliminary estimates for 1996.

Are these real declines or just statistical anomalies? There has been disagreement for a long time about what such numbers mean, how they are interpreted and what should be done about them.

There are two parts to Dr. Bailar's argument: first, that no great progress has been made in curing people of cancer and, second, that resources therefore ought to shift away from treatment and into better prevention and early detection.

A closer look indicates, however, that the medical community has made enormous progress against some cancers and lost ground to others.

The standard examples of progress are the various childhood cancers, of which more than 70 percent are now curable. In fact, cancer mortality has decreased by 25 percent in people younger than 55.

Lung cancer deaths in men also are now decreasing as smoking has been reduced.

Unfortunately, this is not yet the case with women, and our efforts to reduce smoking should be augmented. The lead-

ing cancer killer of women is not breast cancer but lung cancer.

Also important, but not reflected in the statistics, is the progress that has been made for those who can't be cured. We can give cancer patients better, longer lives with less pain, less surgery and fewer and milder side effects from more-targeted, less-toxic treatments.

Perhaps most promising of all is the truly remarkable progress that has been made in understanding the essence of cancer, the molecular biology of what causes it, what goes wrong when normal cells turn malignant and how they spread through the body and escape everyone's best efforts to get rid of them.

Researchers and doctors are just beginning to tap into the potential of this knowledge.

The discussion brings to mind a patient I treated 25 years ago during a period when the federal government was trying to struggle out of, or deny the existence of, an economic recession. The patient was an economist, and I was kidding her about the lack of progress in her field.

"What do you people do all day?" I teased her. "Why can't you figure out how to prevent this?"

"A surprising question for a cancer doc," she replied pointedly. "Just because a problem is hard doesn't mean we should give up on it. It may be that its difficulties require even greater efforts from us."

Cancer is a hard problem. More realistically, it's a bunch of hard problems:

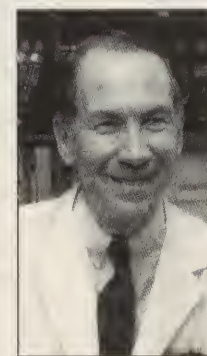
lung cancer, colon cancer, breast cancer and others. Some of the easier ones already have been solved, and now the rest of them must be tackled. It will take time and money.

Efforts for cancer prevention should increase. Considerable strides have come from reducing smoking and emphasizing a better diet, and certainly a great deal more can be done.

Resources can go toward both treatment and prevention; they are not mutually exclusive.

The metaphor of the "war" on cancer is instructive. Dwelling on cancer mortality now is like gauging the battle against Hitler by studying a map of Europe on June 5, 1944, the day before D-Day. Most of the map would be covered with swastikas, dominated by the Axis powers.

But looking closer, one could see that lots of Allied troops with a huge arsenal of war materiel were massing around the edges, preparing to invade. Less than a year later, the swastikas were all gone.



Dr. Hellman has served as physician-in-chief at New York's Memorial Sloan-Kettering Cancer Center and dean of the University of Chicago Medical School. He currently is a distinguished service professor.



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ISMIE Update

What to do when things go **wRong**

Bad outcomes are inevitable, so physicians need to know how to deal with them. BY CHRIS PETRAKOS

For many patients, medical treatment leads to recovery, but for some, outcomes are unavoidably adverse. Given that fact, doctors should know how to handle adverse outcomes.

Bob Baron, an attorney at Rooks, Pitts & Poust in Joliet, said the most important thing is to deal with the situation forthrightly and promptly. When something goes wrong, patients and their families will want to know how and why it occurred, Baron said. Unless the doctor comes forward with an explana-

tion, questions and trouble will follow. "People are bound to have questions on their minds, and if the doctor cannot answer them, they will find a lawyer who will seek an answer. If you are honest about it and explain how it occurred, without being ashamed about what happened, it is generally accepted."

Emotions will be running high, said Peter Monahan, an attorney at Alholm & Monahan in Chicago. "There will probably be a lot of anger from the family; they'll be angry at

the situation, but [the anger] will be focused on the doctor. And that's difficult for the doctor, as it would be for anybody. The doctor is upset about it too, but there should be no apology. This doesn't mean not to express sympathy, which is entirely appropriate."

In cases of death, it may be appropriate to request an autopsy to determine the exact cause of death, and in those cases, delay in talking to the family is inevitable. "There are times when doctors will start saying

all kinds of things because of their own perception of what they did, and that's a mistake," Baron said. Instead of discussing the death with the family right away, physicians should invite family members to come back in two or three days, when they have the autopsy results and can provide more than perceptions about what went wrong.

If a sponge or instrument is left inside a surgical patient, the patient should be told directly, Baron said. "You inform the patient that the surgery will be done over at your own expense. If there are any other medical bills that stem from the event, you take care of them."

Documentation of informed consent is especially important with adverse outcomes, said John Knaus, MD, an Ob/Gyn in Evanston and a member of the ISMIE Ob/Gyn Risk Management Subcommittee. He said that he advocates more widespread use of standardized informed consent forms. "Rather than me sit and talk to

a patient about the complications of a hysterectomy, if I could also give them a piece of paper that explained some of the things that could happen — that I could cut their ureter, that they might need blood transfusions — it would be valuable. But without it, when adverse outcomes occur, patients can claim the doctor never told them what could happen.

"The more informed the patient, the better it is for the physician," Dr. Knaus continued. "In fact, I offer the patient a whole spectrum of information. Do they want to know a lot or a little about their condition? If they want to know a lot, I'll give them material to read, articles, et cetera."

Recent studies suggest that a good bedside manner results in a stronger physician-patient bond and can prevent lawsuits even when adverse outcomes are involved. Monahan said he has been involved in cases in which patients sued all but one of the treating physicians involved in their care. "Later, the plaintiff's lawyers have told me that their client did not want to sue that particular doctor. They felt that the doctor had tried and had done a good job, and they refused to include him in the lawsuit, even though it made their case weaker." ■

MALPRACTICE ROUNDUP

Jury awards \$990,000 for delay in diagnosis of breast cancer

A jury in Worcester County, Mass., found that by failing to examine a lump in a patient's breast in a timely manner, a primary care physician delayed her treatment for breast cancer. The jury awarded the patient \$600,000 plus \$390,000 in interest, according to the March issue of Medical Litigation Alert.

After finding a lump in her right breast during a self-examination, the patient, who had a family history of breast cancer, called her primary care physician. The doctor's secretary sent the patient for a mammogram. The primary care physician received a report from the radiologist that there was no radiographic evidence of a malignancy and phoned the patient to reassure her about the lump. The patient asked the physician for another office visit and a repeat mammogram in three months. Instead, the physician recommended a mammogram in six months and did not suggest an office visit. About six months later, the lump had changed shape, and the patient saw her Ob/Gyn. A biopsy of the lump revealed infiltrating ductal carcinoma, and the patient underwent a mastectomy.

The patient's medical experts maintained that the primary care physician's failure to examine and evaluate the lump when it was first reported led to a seven-month delay in diagnosis and treatment. They also said the physician's reliance on the patient to follow up with the lump and his failure to record details about the size, shape and location violated the

standard of care. The plaintiff's attorneys argued that relying on the mammogram alone was improper, since the reports have a 10 to 15 percent false negative rate. The attorneys also charged that the radiologist misread the radiograph.

Courts consider MCO liability in physician malpractice cases

Courts are considering whether managed care organizations that fail to select competent physicians are liable for negligent credentialing, according to the May issue of Medical Benefits newsletter.

In *McClellan vs. Health Maintenance Organization of Pennsylvania*, a Pennsylvania court held that a plaintiff had a cause of action against an IPA-model HMO for liability resulting from the actions of a physician with whom the MCO contracted. The court stated that HMOs have the duty to use reasonable care when selecting and retaining physicians.

In another case, *Harrell vs. Total Health Care Inc.*, a Missouri court assumed that a health service corporation's failure to investigate a physician's competence might establish a case for the organization's liability. But the court found that the corporation was protected by a state statute exempting such organizations from liability for physician malpractice. Consequently, the court ruled that the corporation couldn't be held liable for negligence in credentialing a physician who may have been negligent.

Office practice seminars offered

ISMIE policyholders and their office staff are invited to attend a half-day seminar on how to incorporate effective risk management procedures into their practices. "An Essential Office Practice" will be offered at statewide locations through November.

The program explains the role of communication in preventing patient injury and litigation, and office procedures related to medical record access and retention. Participants will also learn about patient follow-up, managed care issues and legal implications in treating minors.

Upcoming seminars will be held Aug. 21 at the Eagle Creek Resort in Findlay, Sept. 3 at the University Club in Chicago, Sept. 4 at Rend Lake

Resort in Whittington, Sept. 18 at the Mezzaluna Restaurant in Kankakee, Oct. 15 at the Holiday Inn O'Hare in Rosemont, Oct. 23 at the Springfield Hilton, Nov. 6 at the Clock Tower in Rockford, and Nov. 13 at the Collinsville Holiday Inn.

The seminar carries up to three hours of Category 1 credit for the AMA Physician's Recognition Award. Registration at all sites will begin at 8:30 a.m., with the seminar beginning a half-hour later and concluding by noon. The program costs \$10 per person. For more information and a registration form, call the ISMIE Risk Management Division at (312) 782-2749 or (800) 782-4767, ext. 1327.

Why physicians, legislators should become partners

Session breaks provide a good opportunity to join forces.

BY DON PHILLIPS

Physicians may think they can join state legislators in taking a break when the spring legislative session ends. But it's a good idea to contact lawmakers when the General Assembly isn't in session, according to Rep. Jeff Schoenberg (D-Wilmette). "Unlike physicians, who are trained during their residencies to perform Herculean tasks with little or no sleep, legislators often can take only a cursory look at issues during the latter months of the General Assembly's session.

"Physicians can make the greatest difference if they volunteer to spend a little time in a relaxed setting where they can discuss complex health care policy issues and give legislators a deeper understanding of what the issues are and how their patients are affected," he continued. Schoenberg explained that he has developed a health policy think tank of physicians and hospital administrators in his district, which has a high concentration of doctors. "As a layman, I rely heavily on professionals who can provide me with reliable and solid information rather than political spin."

Physicians may be missing that opportunity to provide information — especially considering the personal zealotry of some other health care professionals, said Rep. Gwenn Klingler (R-Springfield). She pointed out that despite increasing state and national legislation that affects the practice of medicine, "other health professions are much more involved in the political scene than physicians, and they are making much more of an impact. For example, optometrists flooded the Capitol during hearings on amending the Pharmacy Practice Act." The bill would have allowed therapeutically certified optometrists to prescribe therapeutic ocular pharmaceutical agents.

"I even had five optometrists in my office at one time," Klingler said. "Yet I had only one call from a physician — an ophthalmologist. I'm sure [optometrists'] involvement had a lot to do with passage of the bill. I see the same level of involvement with psychologists in their battle for admitting privileges without physician supervision."

Klingler recommended that physicians get to know their representatives and senators. "Fundraisers and other social-political events are excellent places to meet political leaders," she said, adding that physicians are "notorious" for their lack of attendance at political events. After the passage of state tort reform, a fundraiser was held for the House Republican Campaign Committee and offered

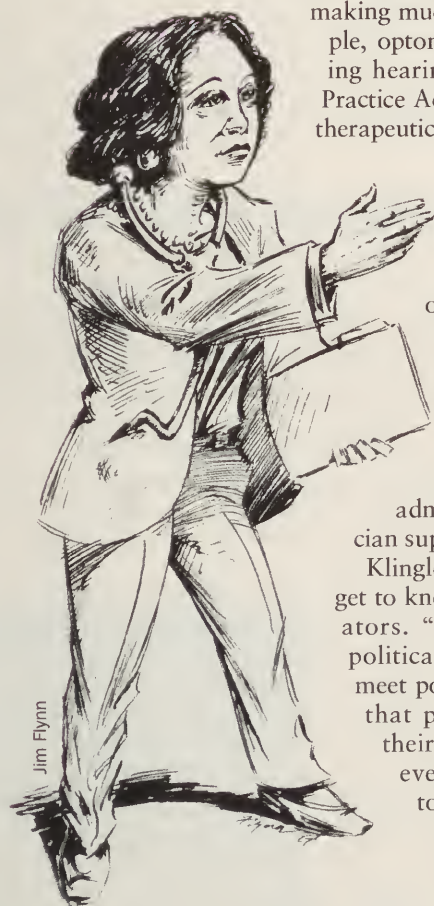
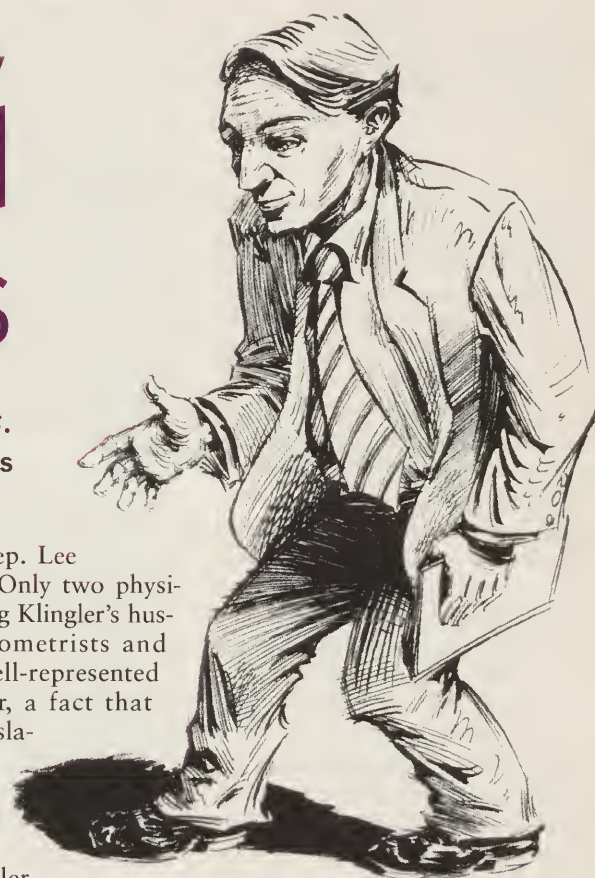
the chance to meet Rep. Lee Daniels (R-Elmhurst). Only two physicians, one of them being Klingler's husband, attended. Optometrists and chiropractors were well-represented at the event, however, a fact that wasn't lost on the legislators attending.

If physicians are too busy with their practices to attend political events, Klingler suggested they call their legislators' district offices or write letters expressing their concerns. To get the most attention, offer concise messages that present well-considered reasons for your positions, she advised.

One politically savvy physician, James Turner, MD, from Marshall, suggested using involvement with ISMS and specialty societies as springboards for legislative activity. Dr. Turner is a member of ISMS' Governmental Affairs Council and serves as chairman of the Committee on National Legislation for the Illinois Academy of Family Physicians. "Organizations, through their various committee structures and advocacy programs, offer physicians many opportunities to jump on the political bandwagon," he said.

This spring, Dr. Turner met Sen. Judy Myers (R-Danville) at a Springfield dinner and discussed rural health care issues. "We talked primarily about rural health care issues."

(Continued on page 11)



Jim Flynn

IMPAC is ongoing

Political activities require not only personal interaction with lawmakers but also financial support. Physicians may tend to think about the Illinois State Medical Society Political Action Committee before an election because IMPAC participates primarily in elections for legislative offices in the General Assembly and the U.S. Congress. But in reality, state and federal candidates host fundraisers year-round. IMPAC Council Chairman Jere Freidheim, MD, said, "Candidates must raise funds every chance they get, so it's important to replenish IMPAC's resources during the off times of elections. In turn, IMPAC supports candidates who share medicine's views throughout the year."

IMPAC is a voluntary, nonprofit, membership organization that functions as the unified political action arm of Illinois physicians and their spouses. The program operates in tandem with ISMS' legislative objectives, but the funds collected through IMPAC memberships are administered independently. Political contributions to IMPAC are administered by the physicians who serve on the IMPAC Council, which also raises funds through mail solicitations, hospital medical staff presentations and peer-to-peer recruitment programs.

For more information about IMPAC, call (800) 782-ISMS or (312) 782-1654.



AMA, ISMS

(Continued from page 1)

ical matter between the patient and the physician, subject to the physician's clinical judgment, the patient's informed consent and the availability of appropriate facilities.

- Encourages use of the term "intact dilatation and extraction" rather than "partial-birth abortion" to refer to a procedure that involves deliberate dilatation of the cervix, instrumental or manual conversion of the fetus to a footling breech, breech extraction of the body except for the head, and partial evacuation of the intracranial contents of the fetus to deliver vaginally a dead but otherwise intact fetus.

- Recommends that intact D&X be used only if alternative procedures pose a materially greater risk to the patient. The physician must have the discretion to make that judgment, acting within the standard of good medical practice and in the patient's best interest.

- States that the viability of the fetus and the time when viability is reached may vary with each pregnancy. During the second trimester, the physician should use the latest diagnostic technology to determine viability.

- Recommends that abortions not be performed in the third trimester except in cases of serious fetal anomalies "incompatible with life."

- Urges AMA collaboration with the American College of Obstetricians and Gynecologists and the American Academy of Pediatrics to develop clinical guidelines for induced abortion after the 22nd week of gestation.

- Encourages the U.S. Centers for Disease Control and Prevention and state health department officials to expand their surveys of induced abortions. That expansion would elicit a more detailed breakdown of the prevalence and type of abortion by gestational age, and the maternal and fetal indications for the procedure. It would also track the short- and long-term complications.

- Describes the AMA's intentions to work with specialty societies, govern-

Illinois resolutions

(Continued from page 1)

Medical Service and accepted by the house. The council report encouraged the development of more options to allow uninsured children to get services through the private sector. The report also provided guidelines for evaluating any federal proposals to increase uninsured children's access to health care services.

A resolution calling for a study on discrimination against employees with chronic illnesses or at high risk for chronic illness was referred to the AMA Board of Trustees for study and report back at the next interim meeting. The medical service reference committee noted that the AMA's current policy urges employers and insurers to adopt policies and practices to preserve patient confidentiality in the workplace and that the Americans with Disabilities Act protects employees and potential employees who have chronic illnesses.

The AMA house also adopted several public health resolutions approved by the ISMS house in April. One substitute resolution, which included the

intent of an Illinois measure, asked car-makers to improve designs to reduce the risks of being trapped in cars after natural disasters or accidents have rendered electric windows or door locks inoperable. A second Illinois resolution adopted called for the AMA to support divestment of any tobacco company stocks by the Teachers Insurance and Annuity Association-College Retirement Equities Fund.

Delegates approved an amended report reaffirming the organization's opposition to legalizing drugs and recommending comprehensive research about the effects of relaxing drug laws. The report, which came from the AMA Council on Scientific Affairs, was approved in lieu of an Illinois resolution asking the AMA to collect, review and evaluate data on the decriminalization of drug use.

An Illinois resolution calling for a moratorium on the implementation of the U.S. Department of Health and Human Services' Model Compliance Plan for Clinical Laboratories was adopted by delegates. The resolution also asks the AMA to work with the U.S. Health Care Financing Adminis-

tration to make sure any corrective action taken by the federal agency addresses the lab fraud identified.

An approved substitute resolution that directs the AMA to develop a less expensive way to update CPT code-books is based in part on an Illinois resolution. Delegates also passed an Illinois resolution that requires the transfer of prepaid dues from members who move, transferring from one county or state medical society to another.

The house reaffirmed a board report that reflected the intent of an Illinois resolution asking for fair reimbursement under the Medicare RBRVS fee schedule.

In response to three Illinois resolutions, delegates also reaffirmed AMA policies on the elimination of insurance gag rules, the incremental change in health care reform and the open meetings policy of the AMA board.

The house chose not to adopt Illinois resolutions dealing with the investigative proceedings of outside agencies and tax credits for physicians involved in charity work.

— Jane Zentmyer

ment agencies, private foundations and other interested groups to educate the public about pregnancy prevention and the need for women who want induced abortions to terminate pregnancy as soon as possible.

ALONG WITH DISCUSSING the report, delegates debated the AMA's support for H.R. 1122, federal legislation banning intact D&X. In May, the AMA's Board of Trustees decided to support the bill but only after it had been "significantly changed to substantially meet the criteria established by the board," according to the AMA reference committee's report. Those criteria require legislation to provide a formal role for medical peer determination in any enforcement proceedings, allow physicians to use their best clinical judgment in performing the procedure

only in extraordinary circumstances in which the patient would otherwise be seriously endangered and use specific, narrow language, so that restrictions are clear.

Delegates ultimately approved both the study report and continued support for H.R. 1122 as amended. They also voted to keep working with state legislators on bills to refine language, especially any provisions dealing with criminal penalties.

Speaking on behalf of the Illinois delegation, AMA delegate Edward Fesco, MD, said, "We were united on the partial-birth abortion procedure being outlawed and effectively got our message to the [AMA] House of Delegates and other states that felt as strongly."

ISMS Chairman of the Board of Trustees M. LeRoy Sprang, MD, said, "This is a clear example of how local

physicians working through their state medical societies can influence the AMA's policies that relate to national health care."

At the ISMS Annual Meeting in April, delegates considered a resolution dealing with ISMS Board of Trustees' support for state legislation that would ban intact D&X and impose criminal sanctions against physicians who performed the procedure illegally.

Dr. Sprang explained the ISMS board's decision at the reference committee session. Although the Society would have preferred that any such legislation refer physicians to the Illinois Department of Professional Regulation for penalties, the inclusion of criminal penalties in the bill was not enough to oppose a ban on "the practice of an egregious procedure that is not sanctioned by the medical profession," he said.

The Society's House of Delegates ultimately approved a resolution supporting a ban on intact D&X and stating that the board would support future legislation that included criminal penalties for procedures only with the approval of the majority of delegates — either at the house meeting or through mail ballot.

During the spring legislative session, ISMS supported H.B. 382, state legislation that defines partial-birth abortion and prohibits its use except in limited, specified circumstances. Gov. Jim Edgar used an amendatory veto on the bill, which will go back to the General Assembly for concurrence. ■



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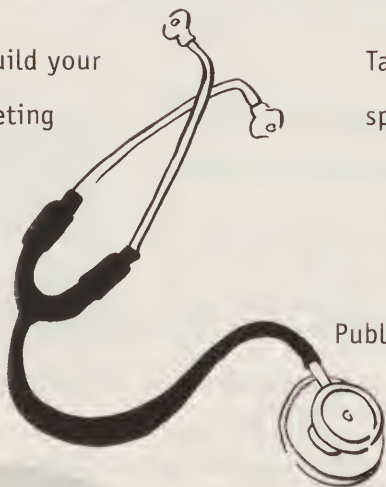
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Governor signs

(Continued from page 1)

result of those tests," the governor said. "People who desire genetic testing should not have to worry that test results will be used against them in the future by insurers."

Moffitt said he introduced the bill after a constituent who wanted to be tested for the ovarian cancer gene came to him for help on the confidentiality issue. She went public with her story after tests showed she didn't carry the gene.

INSURANCE PORTABILITY

Although Congress enacted the Kassebaum-Kennedy bill last year, states had to enact their own legislation to comply with the federal statute. Gov. Edgar signed the Illinois version – S.B. 802 – on June 26. Sen. Robert Madigan (R-Lincoln) and Rep. Carolyn Krause (R-Mount Prospect) sponsored the Illinois Health Insurance Portability and Accountability Act.

The law requires Illinoisans to meet certain requirements in individual and group insurance markets to qualify for health insurance without pre-existing condition exclusions. For the individual market, Illinois chose an "acceptable alternative mechanism" that gives anyone who meets federal eligibility requirements the chance to get coverage without pre-existing condition exclusions through Illinois' Comprehensive Health Insurance Plan. The federal eligibility requirements include having no other group, Medicare or Medicaid coverage; having exhausted all COBRA coverage and having at least 18 months of credible health insurance coverage without a 62-day break.

FEMALE GENITAL MUTILATION

Female genital mutilation became a Class X felony in Illinois when Gov. Jim Edgar signed H.B. 106 on July 11. Rep. Rosemary Mulligan (R-Des Plaines) and Sen. Adeline Geo-Karis (R-Zion) were lead sponsors of the bill in their respective houses. The ISMS House of Delegates adopted policy in 1996 condemning the practice, calling it a form of child abuse.

The two procedures involved in female genital mutilation are clitoridectomy, which excises the clitoris, and infibulation, which claps or stitches the labia minora to prevent sexual intercourse. Illinois law exempts surgical procedures performed in connection with labor or childbirth. Male circumcision is also exempted. A federal ban on the practice became effective April 1.

BAN ON INTACT DILATATION AND EXTRACTION

On July 17, Gov. Jim Edgar exercised an amendatory veto on H.B. 382, which bans intact dilatation and extraction (intact D&X), or partial-birth abortion. The amendment deletes a provision that would have allowed biological fathers to take legal action against physicians who performed the procedure.

The governor's staff reviewed legislation that was enacted or considered in 42 other states, and only two have given standing to unmarried biological fathers, he said. "I fear that unconditional approval of this legislation could create an undesirable precedent by granting biological fathers legal standing in matters of abortion. This could be the first step toward allowing fathers to interfere in a decision that I believe should rest with a woman and her doctor."

Regarding the intact D&X proce-

dures, Edgar said, "My understanding is that this procedure rarely has been used in Illinois, and I believe it should be outlawed unless, as provided in this legislation, continued pregnancy would threaten the woman's life. H.B. 382 essentially prohibits a barbaric procedure that is repugnant to me and to almost all Illinoisans."

H.B. 382 now returns to the General Assembly, which must concur with the governor's action or vote to override it and restore the original language before the legislation can become law. Rep. Peter Roskam (R-Wheaton) and Sen. Chris Lauzen (R-Geneva) sponsored the bill. ■

Why physicians


(Continued from page 7)

health issues – what it's like to practice and represent an underserved area and how important it is to have a physician in a town for economic viability and community growth." Several weeks later, Myers toured a rural physician practice training program Downstate. "What started out as an informative session on rural health has blossomed into a trusting relationship," Dr. Turner said.

Schoenberg said that physicians and legislators share the responsibility for open communication. For instance, he

uses an annual memo outlining key legislative policy developments to communicate with health care professionals.

As a sponsor of ISMS' Managed Care Patient Rights Act and vice chairman of the House Human Services Committee, Schoenberg knows about the challenges physicians face. "Even though the economics of medicine have changed tremendously and physicians find themselves putting in extra time to manage their practices efficiently and effectively, it's still in their best interest to become close partners [with legislators] in effecting health care reform initiatives." ■



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PAGE 7

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criminal acts**

PAGE 5

Consumer groups talk to state senators about need for managed care reform

HEARING: Patients want more information about their health care plans, according to testimony. BY JANE ZENTMYER

[SPRINGFIELD] After a three-month hiatus, the Illinois Senate's Managed Care Subcommittee resumed its work at a July 23 hearing in Springfield. Senators heard from consumer groups and others about issues that should be considered in developing comprehensive managed care reform legislation. Senators will use the July testimony, along with testimony from a hearing in April and other hearings planned for later this year, to craft its own reform bill.

"There is no question we all recognize that the health care system is transforming rapidly into a managed care system. As this occurs, consumers need guidance and assurance that managed care is operating in their best interests," said Kate McLachlan, former associate director of the Chicago-based



Ron Ackerman

Health and Medicine Policy Research Group. "A consumer protection bill can provide assurance."

Members of the American Association of Retired Persons attended the hearing wearing "Act [on] 626 now" buttons to show their support of managed care reform and H.B. 626, a comprehensive measure. The bill incorporates feedback from House hearings held this spring and was passed by the House.

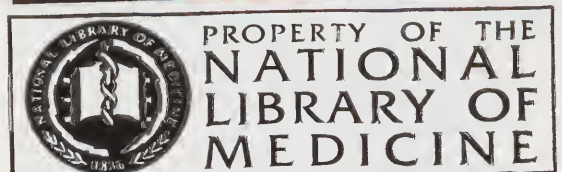
When H.B. 626 arrived in the Senate, it was assigned to the Managed Care Subcommittee and was supported by groups including ISMS at the April hearing.

At the July hearing, John Herman Sr., chairman of AARP's state legislative committee for Illinois, said, "We find the issues surrounding managed care to be a consumer protection issue." A survey of AARP members showed that they are primarily concerned about access to care, choice of providers, consumer representation, quality of care and consumer information. Herman said that those concerns are addressed by H.B. 626, which requires annual consumer satisfaction surveys and patient confidentiality protections.

Several consumer groups said
(Continued on page 11)



Jon McGinty



ROCKFORD OB/GYN ERIC SHADLE, MD, and family physician Christine Petty, MD, field questions about a ban on tubal ligation that will be enforced after the merger of SwedishAmerican Health System and Catholic-operated OSF HealthCare System. The news conference was held July 22. See story, page 3.

MediPlan Plus enrollment scheduled for 1998

DELAY: IDPA applies for extension of waiver.

BY JANE ZENTMYER

[SPRINGFIELD] The Illinois Department of Public Aid submitted an application to the U.S. Health Care Financing Administration July 12 requesting an extension of the waiver granted in July 1996 to implement MediPlan Plus, the proposed program to move Medicaid enrollees into managed care. "They're in the process of reviewing [the extension request]," said George Hovanec, IDPA administrator for the division of medical programs. "We confidently expect it's going to be approved."

As part of its application to HCFA, IDPA also sent a revised implementation schedule for MediPlan Plus and a list of activities undertaken in 1997 related to the program. Medicaid recipients can enroll in MediPlan Plus beginning in August 1998, according to the revised schedule. Physicians who want to provide or arrange services for Medicaid

recipients can enroll in March 1998. ISMS will continue to monitor MediPlan Plus as it moves forward, said John Schneider, MD, chairman of ISMS' Third Party Payment Processes Committee.

MediPlan Plus is designed to improve health care delivery for Medicaid recipients and to control costs through managed care. The waiver permits IDPA to assign managed care providers to those recipients who fail to select one, to lock enrollees into their chosen or assigned provider for one year and to develop Managed Care Community Networks, which will contract directly with IDPA. MCCNs are managed care entities that provide or arrange for health care services, but unlike HMOs, they may treat only MediPlan Plus enrollees.

Gov. Jim Edgar proposed MediPlan Plus in March 1994.

(Continued on page 11)

IDPA accepts bids from eight HMOs

MEDICAID: Contract negotiations are in progress.

BY JANE ZENTMYER

[SPRINGFIELD] On July 28 the Illinois Department of Public Aid notified eight HMOs that they met the state's requirements to provide health services to Medicaid recipients through the state's voluntary managed care program, according to George Hovanec, IDPA's administrator of the division of medical programs. New contracts are expected to be effective as of Nov. 1 and will mark the first time IDPA has expanded its voluntary managed care program beyond Cook County.

To qualify, plans had to score at least 325 points in areas such as size, financial backing, quality assurance programs, experience with Medicaid and marketing plans. The eight bidders that qualified are Accord Health Plan, Westmont; Americaid Community Care, Chicago; Community Health Choices of Illinois, Chicago; Harmony

Health Plan of Illinois, Chicago; Humana Health Plan, Chicago; Illinois Masonic Community Health Plan, Chicago; UIHMO, Chicago; and United Health Care of Illinois, Chicago.

Four plans have been given an opportunity to amend their proposals, according to IDPA. They are American Health Care Providers, Matteson; Illinois Health Care, Bloomington; Maxicare Health Plans of the Midwest, Chicago; and Unity HMO of Illinois, Chicago. Hovanec said those four plans would have until the end of August to amend their proposals.

Except for Illinois Health Care, the other 11 HMOs are currently providing health care services to Medicaid recipients in Cook County. IDPA's contracts with those 11 HMOs expire Sept. 30, and the department has offered them a one-

(Continued on page 11)

INSIDE

**Remembering
Dr. Raymond
Hoffmann**

PAGES 2, 4

**Breast cancer
summit set for
October**



PAGE 2

DEPARTMENTS

**Malpractice
Roundup.....6**

Classifieds9

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Remembering Dr. Hoffmann



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John McNulty

RAYMOND HOFFMANN, MD, died on July 23 but will long be remembered for his contributions to medicine and ISMS. In his role as speaker of the House of Delegates in 1992 (above), he confers with Vice Speaker Ulrich Danckers, MD, on the rules of parliamentary procedure. Dr. Hoffmann and his wife, Nancy, (above, center), help Alan Roman, MD, celebrate as outgoing ISMS president at the President's Night dinner in 1995. Later that weekend, Dr. Hoffmann was inducted as

ISMS president. Joining him immediately after his induction (above, right) are (back row) son, Nathan, and son-in-law, Peter Asplin, and (front row) wife, Nancy, and daughter, Kristen. At Dr. Hoffmann's own President's Night dinner in 1996 (right), he jokes with long-time friend William Kobler, MD. At a news conference in February 1996 (far right), Dr. Hoffmann talks to the media about patients' problems with managed care and the need for reform.



John McNulty



John McNulty

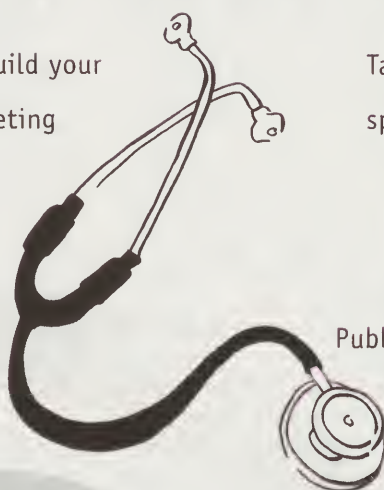


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Chicago breast cancer summit set for October

[CHICAGO] Primary care physicians are often the entry point into the health care system for breast cancer patients. To help primary care physicians get the latest information on breast cancer screening and treatment, the University of Chicago Cancer Research Center will hold the Illinois Breast Cancer Summit on Oct. 31 at the Drake Hotel in Chicago.

The one-day summit, "Practical Issues in the Diagnosis and Management of Breast Cancer," is the first one the center has targeted for health professionals. It will cover several topics including risk factors for breast cancer, mammography screening, follow-up of breast cancer patients, treatment decisions, genetic testing and the reasons behind lawsuits related to breast cancer diagnosis and treatment. The Illinois Department of Public Health and the Y-ME National Breast Cancer Organization will co-host the summit, which is offered in association with ISMS and the Illinois Academy of Family Physicians.

The program is geared toward, but not limited to, primary care doctors including family physicians, internists, Ob/Gyns and geriatricians, and will cover the relationship between primary care physicians and oncologists. An internist and an oncologist will offer their perspectives on who should manage various aspects of patients' care, what primary care physicians and oncologists should expect from each other and when primary care physicians should refer patients.

Program participants may earn a maximum 5.75 credit hours in Category 1 of the AMA Physician's Recognition Award, as designated by the University of Chicago Pritzker School of Medicine. In addition, the American Academy of

Family Physicians will grant 5.75 hours of CME.

The registration fee, which includes materials and meals, is \$50 for physicians and \$25 for residents, fellows, genetic counselors, nurses and allied health professionals. No refunds will be given after Oct. 23, and a \$25 administrative fee will be charged for cancellations before that date.

For more information or a registration form, call the University of Chicago's Center for Continuing Medical Education at (773) 702-1056.

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Rockford doctors object to tubal ligation ban

CONTROVERSY: Physicians express concern about the policy they must follow after hospital merger. BY PATIENCE KRAMER

[ROCKFORD] Despite physician concerns about limitations on procedures like tubal ligations, the board of trustees of SwedishAmerican Health System in Rockford voted at its July 28 meeting to continue plans to merge with Catholic-operated OSF HealthCare System, which operates Saint Anthony Medical Center in Rockford. As a Catholic-operated organization, OSF HealthCare System and its member facilities don't perform voluntary sterilization, such as tubal ligations, vasectomies and abortions, and don't allow birth control measures to be prescribed. After the merger, which was announced in April, Rockford's SwedishAmerican Hospital will follow OSF policy.

On July 22 seven physicians from SwedishAmerican Hospital, which is owned by SwedishAmerican Health System, called a news conference to air their concerns about contraceptive issues. In a subsequent interview with Illinois Medicine, news conference spokesperson and Ob/Gyn Eric Shadle, MD, said he was most concerned about the inability of Ob/Gyns to perform sterilization procedures, specifically tubal ligations in conjunction with emergency cesarean sections, after the merger. Such tubal ligations would have to be done after the c-section in a facility not governed by the OSF Healthcare System guidelines. "Not to be able to tie [a patient's] tubes while her abdomen is open is, I think, close to malpractice," said Dr. Shadle, who is immediate past chairman of the hospital's Department of Obstetrics and Gynecology.

"We will not oppose the merger, but we will oppose this aspect — not being able to perform tubals — and we want a solution," Dr. Shadle explained. "The main thing we are opposed to is anyone telling us how to provide contraceptive management outside the general guidelines of good medical care. We feel that we should be governed by the standard of care in this country."

Dr. Shadle said his group had talked to SwedishAmerican officials about the possibility of having at least one surgical suite that would be owned by an organization other than OSF or SwedishAmerican and that would be excluded from the merger agreement so that tubal ligations could be performed there. Another option would be for the SwedishAmerican Medical Foundation, which is not included in the merger agreement, to own one of the operating suites, he added.

Regarding the option of a suite within the hospital dedicated to emergency c-sections and planned tubal ligations, SwedishAmerican Chief Executive Officer Robert Klint, MD, said, "It's been done elsewhere. It's coming under increasing disfavor, and it's not an option that we have."

"Some aspects of Ethical and Religious Directives are not negotiable," Dr. Klint added. "[They are] part of the conditions of new ownership. I would not want to send signals that we are sitting down and negotiating Catholic ERDs."

David Schertz, administrator for Saint Anthony Medical Center, said, "The position is, those [sterilization] procedures will not be performed in any facilities that are owned and operated by the

Order of Saint Francis."

"The independent Obs and family physicians who deliver will still be able to provide those services, and those services will be able to be provided at Rockford Memorial Hospital or Rockford Ambulatory Surgery Center," said SwedishAmerican Health System Vice President Tom Myers.

Rockford Ambulatory Surgery Cen-

ter, which is free-standing, and Rockford Memorial Hospital, which is owned by Rockford Health Systems, both allow sterilizations. As part of the merger agreement, SwedishAmerican Health System will divest itself of interest in the Rockford Ambulatory Surgery Center, with which it is currently in a limited partnership.

Dr. Klint explained that most Ob/Gyns at SwedishAmerican have offices at Camelot Towers, which will not be included in the merger and will not be owned by OSF. "Therefore, the reaches of the directives don't touch their offices."

Schertz said the number of patients

potentially affected would be small. "SwedishAmerican performed 291 tubal ligations last year, 70 of which were performed following c-sections. The issue has been raised about an emergent procedure. I'm not aware of any emergent tubal ligations. The individual who wants the procedure could make her physician aware of that ahead of time, and the whole procedure could be scheduled at Rockford Memorial Hospital."

OSF HealthCare System and SwedishAmerican Health System are preparing to file a merger request with the U.S. Department of Justice within the next 30 days, according to Myers. ■

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EDITORIAL

Good-bye to a good friend

ISMS and Illinois Medicine lost a very good friend on July 23. Dr. Ray Hoffmann was one of those people who are exceptionally talented but so nice and down-to-earth that you sometimes forget how extraordinary they are. His clinical accomplishments were many. He was a board-certified general surgeon, vice president of Rockford Surgical Service, first vice president of the medical staff at OSF Saint Anthony Medical Center, chairman of the board of directors of the Blackhawk Area Medical Association and clinical associate professor at the University of Illinois College of Medicine at Rockford.

Then there were his organized medicine achievements. He served as speaker of the ISMS House of Delegates for two terms and president in 1995, and was a member of the ISMS Board of Trustees, the ISMIE Board of Governors and the Illinois delegation to the AMA.

He wasn't just accomplished, though; he was also a family man. He talked a lot about his wife, Nancy – the person from whom his kids inherited their brains, he used to say. He was especially proud that Nancy had served as president of the ISMS Alliance in 1989. He was also proud that his son, Nathan, had graduated from Johns Hopkins and was working on an MD/PhD degree, and that his daughter, Kristen, was earning a PhD in behavioral psychology.

Dr. Hoffmann served on the Illinois Medicine Committee since the publica-

tion's inception. Even if there was a snowstorm on the day of a committee meeting, he'd make it from Rockford somehow. During his ISMS presidency, when he was traveling extensively, he insisted on staying on the committee because he wanted to contribute. He did contribute story ideas, usually dealing with his favorite subject – computer technology. But he also contributed his sense of humor, his support and his enthusiasm.

When Dr. Hoffmann said that medicine is the best profession there is, he meant it. In his first "President's Letter," he wrote, "What other profession can give life back to those people who are near death? What other profession has the compassion and knowledge to help people die with dignity? These are our patients who count on us."

His patients were very important to him. In an Illinois Medicine interview, he talked about how he always tried to put patients at ease. "My goal is to try and leave the patient with a smile on his or her face, even if I have to tell a dumb story about me and my kids."

The members of ISMS were important to him, too. The biggest accomplishment of his presidency, he said, was making 49 trips all over the state. He talked to more than 2,800 people, including 1,900 physicians. At the end of his presidency, he wrote that "the long hours and the lost sleep have been worth it. Because of physicians like you, medicine is the best profession there is."

PRESIDENT'S LETTER

Good-bye Ray, we'll sure miss you!

Jane L. Jackman, MD



July 23 had been a pretty typical Wednesday for me – seeing patients and an afternoon meeting in Chicago – when the call came that evening that Ray Hoffmann, MD, had died. My initial response, as I expect yours was, was that of disbelief. (It can't be! I don't believe it!) Here was a well-liked and apparently healthy general surgeon and medical leader, struck down in his mid-fifties by a sudden illness. Strange, isn't it, that even though we encounter death all the time in our professional capacity, we are still shocked and horrified when it affects us personally. It drives home in a very graphic and vivid way how ephemeral life can be and how short our time on earth really is.

Ray's death brings great sadness to me. We sat next to each other at the ISMS Board of Trustees meetings for five years, and I grew to appreciate his quick wit, his refreshing candor in dealing with difficult issues and his natural leadership ability. Having held many leadership positions himself, he became a mentor to the more inexperienced members of the board. He started working for ISMS as a delegate from Winnebago County and just three years later became vice speaker of the House of Delegates, followed by speaker, then president-elect and on to president in 1995.

I'm sure most of you got to meet him in your home territory, since his sense of commitment and high energy level drove him to visit almost every county medical society, thus making him one of the most well-traveled presidents of ISMS. We all owe a big debt of gratitude to his wife, Nancy, and his children, Nathan and Kristen, for sharing Ray with us and allowing him to spend so much time away from home on ISMS business.

Shortly before I took office, Ray phoned me to ask what he could

do to help me this year. I asked for advice on how to survive the grueling time demands made on the president of ISMS. With typical boyish enthusiasm, he recounted how many wonderful and interesting people he had been privileged to meet during his year, how much fun he had – and he told me to do likewise.

"Having fun" probably characterized Ray's upbeat attitude toward life better than any other description. He was an eternal optimist who enjoyed people. He made friends with everyone he encountered. As

was said at his memorial service, his life was truly a celebration. A hard worker, he enjoyed the tasks he undertook – being a governor of ISMIE, an AMA delegate, chairman of the Downstate caucus, a church leader, a compassionate surgeon and trainer of EMTs at his hospital.

In 1995, Ray worked hard to help us pass tort reform. While ISMS president, he started the ball rolling on managed care reform. (You may remember him in the ISMS video, perched on the edge of an operating table,

telling the world how managed care was affecting his patients.) I am convinced that the best tribute all of us can give to Ray Hoffmann is to carry on the work that he had to leave – to pass comprehensive managed care reform and to see that tort reform remains a reality for our patients. These were issues he felt very strongly about, since both can interfere with the patient-doctor relationship, which is the very foundation of what makes American medicine so excellent.

Good-bye Ray – we'll sure miss you! Thanks for all the time and talent you expended on our behalf. We promise we won't let you down, and we will finish what you set out to accomplish. Who knows, maybe we'll even have fun doing it!

*The best tribute all of us
can give to Ray Hoffmann
is to carry on the work
that he had to leave.*

GUEST EDITORIAL

Honest mistakes aren't criminal acts

By Mark Crane

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A doctor's error in judgment is traditionally a civil matter, unless there's intent to cause harm or blatant indifference to risk. Some activist prosecutors are blurring the distinction between civil and criminal law in a cynical campaign to expand their turf. Indicting physicians makes for catchy headlines.

New York Gov. George Pataki last month commuted the sentence of an internist ordered to spend 52 weeks in prison. Gerald Einaugler's "crime" was to delay hospitalizing an apparently stable nursing home patient. State prosecutors convinced the jury this was reckless endangerment and criminal neglect. Dr. Einaugler served six weekends at Riker's Island before Gov. Pataki acted.

In cases around the county, prosecutors have labeled legitimate conservative treatment as criminal neglect, placing every physician at risk. A Florida state's attorney charged a physician with manslaughter in a patient's death. The indictment was front-page news. When the weak case unraveled, the doctor's vindication was barely noticed. His career was destroyed.

Unfortunate outcomes happen despite the best of care, but inflammatory rhetoric of the "someone should pay" type can have several undesirable effects. It can sway jurors.

It worries leaders of the medical profession lest malpractice settlements serve as ammunition for unwarranted prosecutions. It makes it harder for physicians to gauge whether their conduct of a case might be considered illegal. The "crime" is determined in hindsight.

That's what happened in Einaugler vs. Supreme Court of the State of New York. It is true that in reviewing the case, U.S. District Judge Edward Korman said New York prosecutors cared more about publicity than justice and criticized acting Supreme Court Judge Neil Firetog for allowing prejudicial testimony to taint the trial and for botching the jury instructions.

Just the same, Judge Korman said U.S. Supreme Court decisions on habeas limit his authority to set aside an unjust verdict. "I hope I get reversed. Habeas law is a procedural morass. The one thing that everybody has succeeded in doing is making innocence irrelevant, much less reasonable doubt," he said.

A divided federal appeals court also upheld the conviction. There was no expert testimony to the effect that the

"delay" in hospitalization posed a substantial danger. For a century, New York courts have required expert testimony before a civil malpractice case can go to a jury. But a 2nd Circuit panel held in this case that it isn't necessary under the reckless endangerment statute. So, a physician can be jailed based on evidence that isn't strong enough to get him sued.

The Einaugler case began in May 1990 when a terminally ill woman suffering from kidney failure was transferred from a Brooklyn hospital to an

adjacent nursing home. Dr. Einaugler mistook a dialysis catheter for a feeding tube – the hospital had failed to send crucial paperwork. The catheter's location and its resemblance to a feeding tube led to the mistake, the state medical-conduct board ruled when it cleared him.

The error was discovered 36 hours later, and the feeding solution was drained off. The patient was stable when nurses notified Dr. Einaugler of the mistake, and he examined the patient three times that day, as well as seeking help from nephrologist Irving Dunn, MD, who agreed that there was no emergency.

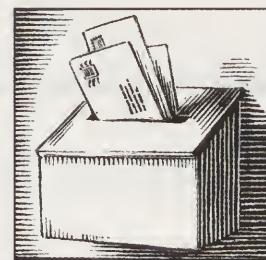
Prosecutors charged that Dr. Dunn said immediate transfer was necessary, although his testimony was ambiguous and hard to follow. Dr. Einaugler ordered hospitalization after nurses noted the patient seemed weaker. She died four

When prosecutors can't distinguish between an honest mistake and criminality, patients are the ultimate victims.

Hats off to physician volunteers

As executive director of Community-Health, I read with interest Dr. Jane Jackman's President's Letter titled "The satisfaction of helping those in need" (May 23).

My accolades go to Dr. Jackman for her time and courage in providing volunteer medical care at one of the 20-plus free clinics in Illinois. Through the actions of altruistic physicians like Dr. Jackman, many of this state's uninsured are being cared for at no cost to the taxpayer. All of us – in the health care community and outside – must band together to help our families, friends and neighbors



who are often penalized for inability to pay for medical care.

Free clinics are founded on the principle that everyone has a talent that can be used for the greater good. Patients, too, are encouraged to give back to free clinics by donating money or volunteering. Although free clinics may never address the entire problem of the medically underserved, these organizations do bring out the best in all of us.

For more information about volunteering in a free clinic or for a list of free clinics, please call (773) 395-9808.

– Buck Taylor
Chicago

Illinois Medicine reserves the right to edit all letters to the editor.

days later: No autopsy was performed, so the cause of death is uncertain.

Later, Dr. Dunn "clarified" his testimony, saying he told Dr. Einaugler only to monitor the patient and that Dr. Einaugler followed his advice responsibly. But because a procedural rule in the 1996 Anti-Terrorism and Effective Death Penalty Act limits successive petitions in a habeas hearing, the appeals court won't acknowledge his new remarks.

Dr. Einaugler did not neglect his patient to play golf. He monitored her all day, sought help from a consultant and hospitalized her the moment there was a downturn.

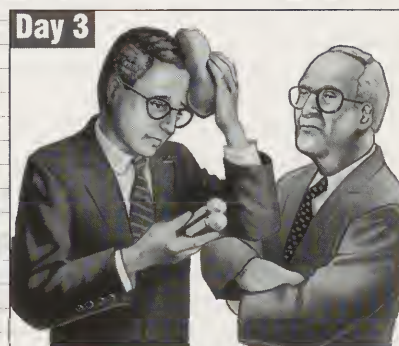
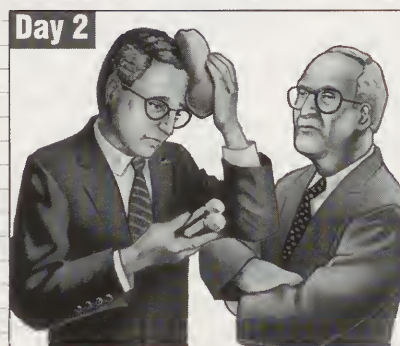
When prosecutors can't distinguish between an honest mistake and criminality, patients are the ultimate victims. Physicians must routinely choose between conservative or aggressive treat-

ment. Each option has a downside. How can a doctor use his best judgment when the penalty for being wrong is jail? Criminalizing medical decisions has a chilling effect on the profession, and nobody would benefit if doctors shunned difficult cases.

Gov. Pataki was brave to commute the doctor's sentence to community service. Justice demands that he go further. A full pardon would tell physicians they can practice without the threat of criminal liability lurking behind every decision. Doctors should not be immune from paying for their mistakes. But the distinction between honest errors and crimes must be based on a higher standard than a prosecutor's quest for publicity.

Crane is a senior editor at Medical Economics magazine.

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ISMIE Update

How to be an expert witness

BY JACK C. CHILDERS JR., MD

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While few orthopedists relish the event, many, if not most, at one time or another, find themselves on the stand as an expert witness. This brief article, from the Academy's Committee on Professional Liability, gives a few pointers on how to survive the experience, with your reputation (and ego) intact.

With a nod to the realty profession, the most important aspects of being a good expert witness are preparation, preparation and preparation. The following are four critical areas of preparation:

1. *Knowledge of the disease process.* Do not assume that because you are a physician and the opposing attorney is not, you will know more about the injury or disease in question than he does. An attorney can, with application, become just as knowledgeable as you in one narrow field of medicine, and his expert witness will have prepared him with questions to probe your knowledge. A little brushing up may be in order. However, when you get on the stand, all your opinions should be based on your training and experience. If you cite books or articles, you open yourself to being questioned on those sources. This is bad because you may not remember everything the cited book or article said, in which case the opposing attorney will certainly demonstrate that to the jury, to your discomfiture. In addition, the source may not agree with you in every particular, in which case the opposing side will impeach your testimony with your own quoted authority.

2. *Knowledge of the clinical facts of the particular case.* Familiarity with the case is essential. You may be sure that the opposing attorney will be familiar with the facts and will



Tomek Olbinski/SIS

try to demonstrate to the jury that you are not. There will likely be questions such as, "Doctor, what is your opinion of the patient's temperature on post-op Day 3?" If you do not know the case, your lack of knowledge will be painfully apparent to the jury as you try to remember whether there was a significant fever on Day 3.

3. *Discussion with the attorney who has called you to testify.* You have the right to know in advance the questions he is going to ask, and he has the right (indeed, the obligation) to know what your answers will be. While he cannot make you a lawyer (any more than you can make him a physician), you should know the effect of your opinions on the outcome. He also should discuss with you the likely questions the opposing side will ask and your answers.

4. *General appearance and demeanor.* Sworn testimony is serious business, with money, reputations and society's best attempt at justice on the line. Dress well but conservatively. If you appear in golfing attire, you

send a message to the jury of your casual opinion of the proceeding. (That may be your opinion, but the jury will consider your opinions as casual too and weigh them accordingly.) Speak distinctly and respond while looking at the attorney who is asking you the questions. When asked to explain something to the jury, look at the jury. Use lay language as much as

possible but do not condescend. When technical terms must be used, explain them.

Finally, a few specific tips:

□ Count to three before answering any question. Many a case has been damaged by a witness blurting out the answer to an inappropriate question before the other side could object. Even though the judge may instruct the jury to disregard, the damage may be done.

□ You are entitled to have at hand any medical records you have made, and to refer to them. Beware the attorney who asks to see your records, shuffles through them, then hands them back to you in disarray, and proceeds to ask rapid-fire questions about them. If this happens, do not try to bluff it through. Ask the judge for a short recess, noting (pointedly) that you need to restore order to your notes.

□ Here's an old trick, but one that still catches the novice witness:

Attorney: "Doctor, do you agree that a thorough history is an important part of evaluating a patient?"

Witness: "Yes, of course."

Attorney: "Well then, doctor, do you agree that asking about (...) is part of a thorough history?"

Witness: "Well, yes."

Attorney: "Now doctor, would you please look in your history of this patient and show me where you asked about (...)?"

The implication of the first two questions is that every part of a thorough history is required on every patient, which is of course untrue. You may be sure that he will have chosen something you didn't ask. The key here is to recognize the trap at the first question and to qualify your first answer that while a thorough history is important, what constitutes a thorough history varies with the patient, disease process, etc.

In addition, be aware of the words "possible," "may," "can," "end" and "suspect" from the attorney cross-examining you. The terms "probable" and "probability" are the important ones to use. Your role as an expert is to assist the jury and help to clarify the issue, not confuse it, as opposing counsel may desire.

Here are a few more tips:

□ Do not allow yourself to be drawn into verbal sparring with the opposing attorney. You will almost certainly lose.

□ If you must explain an answer, most judges will allow you some leeway to do so if requested, but be aware that attorneys become very nervous when a witness gets to speak extemporaneously, and for good reason. You are unlikely to be aware of the legal implications of your explanations. ■

MALPRACTICE ROUNDUP

Drug reaction causes heart attack patient to lose fingers, legs

A Michigan circuit court jury found a cardiologist and a hospital negligent after a heart attack patient reacted adversely to the anti-clotting drug streptokinase. The patient was awarded \$15 million, according to the June 9 issue of the National Law Journal.

In *Badalamenti vs. William Beaumont Hospital-Troy*, the cardiologist prescribed the drug when the patient arrived at the hospital emergency department suffering from a heart attack. The patient's condition did not improve, and his blood pressure dropped drastically. By the time he was transferred to another hospital for an emergency angioplasty, the patient was in cardiogenic shock with a blood pressure of 50/0. As a result, blood was shunted from his extremities to his heart and brain. The lack of blood to his arms and legs caused gangrene, leading to the loss of the man's fingers and his legs below the knees.

The cardiologist's attorney told the jury the patient's problems were caused by a "bizarre idiosyncratic reaction to streptokinase." If the post-trial motions to set aside the verdict are not successful, the defense plans to appeal.

Seller beware

Physicians who are thinking of selling their practices to hospitals should know what pitfalls to avoid.

BY PATIENCE KRAMER

Some hospitals that bought physician practices may have had second thoughts about the arrangement by now. In the past five years, there has been an explosion in acquisition of physician practices with hospitals being the largest category of purchasers, according to the Center for Healthcare Industry Performance Studies. A nationwide study of 460 physician practice acquisitions made from 1994 to 1996 showed that practices acquired by hospitals are not as likely to be profitable as those acquired by physician management companies or medical groups. A recent Wall Street Journal article reported on a Coopers & Lybrand survey that found that 17 hospitals nationwide incurred annual losses of \$97,000 per acquired physician practice.

One reason may be that some hospitals have acted impulsively when purchasing physician practices, according to Crystal Lake attorney and health care consultant Tom Gorey. "One hospital in a community or market made that type of move, and others felt that for defensive purposes they needed to do the same thing."

Some physicians, too, may have sold their practices on impulse, Gorey said. "Too often physicians have made a purely emotional decision, sometimes in a near panic over what's taking place in their markets. Their decisions to sell may be more the result of [worry about] increased competition, selective contracting by payers, declining patient volume and downward pressure on revenues. So, some physicians have signed agreements and later realized there wasn't a need to act quite that quickly." When the decision to sell or purchase a practice isn't a thoughtful one, "physicians see they've sacrificed a fair amount of autonomy for short-term gain and sold off future potential earnings for their practice."

Pam Waymack, of Phoenix Services, a management consulting firm in Evanston, said: "Nationally, hospitals are saying, 'We don't understand the physician practice management business. We set up deals that are bad; it's almost impossible to manage them well; and we don't understand the management to begin with.' At some point hospitals will not be able to sustain significant operating losses in various divisions, and they will have to make business decisions—divesting themselves of practices they have purchased, finding a partner who will manage them or trying to restructure the entire arrangement."

Waymack said hospitals purchased practices "because they thought they were going to get capitated contracts through primary care physicians." But how many of those hospitals will stay committed if the primary care doctors' control over capitation decreases? she asked.

Dave Harrington, a health care consultant with Karen Zupko and Associates in Chicago, said some hospitals are making mistakes that can only lead to serious problems. "They have to grow the managed care area to sustain revenue, and hospitals aren't aggressive about getting managed care contracts. Hos-

pitals haven't demonstrated a willingness to compete on cost and are somewhat ineffective in coordinating care between the resources they manage. As a result, they don't increase the number of enrollees, and their revenues drop."

Harrington said hospitals may blame their problems on reduced physician productivity. "But the reason is that hospitals are not experiencing revenue stream, and the source of revenue is managed care. You can't blame the physician when this happens."

Harrington cited PhyCor, an independent physician practice management company that is actively buying physician practices, as a success story. "When PhyCor buys a group of doctors, it is

able to grow the managed care business coming to the group of doctors in double-digit numbers, as high as 25 percent."

Selling a practice to a hospital can work for physicians, though, "certainly for the physician who's ready to cash out his practice," Waymack said. "But for somebody who's young and has a career in front of them, is this going to be the right partner? Is this going to make them happy? This is why you want to evaluate it well."

THE CONSULTANTS HAD ADVICE for physicians who may be making that evaluation. "It's important to make a rational, objective decision based on an analysis of what's happening in the market and how they can best position themselves in that market," Gorey said.

Waymack suggested probing the hospital about its plans for the practices it has already purchased. "Has the hospital amassed all these practices with no idea how it's going to manage them? For example, is the

(Continued on page 8)



Dave Cutler/SIS

Seller beware

(Continued from page 7)

hospital going to centralize certain core functions? If matters such as this aren't decided up front, it's going to be a rockier marriage."

She also suggested looking at the medical leadership in the group the hospital is creating. "Is it just a hospital-run physician group? Look for some internal physician leadership to make it really a viable practice. Ask other physicians who have joined the hospital-owned group what it's like to be a part of the group."

Physicians should find out the hospi-

tal's approach to managed care, Waymack advised. "Ask, What are your objectives in terms of managed care? How are you perceived by managed care [plans]? If you just married yourself to the highest-cost hospital in town whom the payers avoid like the plague, it could be a death spiral for your practice."

Harrington said, "The hospital needs a business plan with targets that the hospital wants to achieve with the practice." He recommended that physicians and hospitals work together to develop a business vision, or direction, for the practice before the acquisition. That might involve answering such questions

as, Will the practice require a new site? Will it merge with another practice? What new business could be brought to the practice?

Once such questions are answered, physicians and hospitals should collaborate on a solid business plan, Harrington said. The plan should define both parties' expectations, delineate why they are entering into the agreement and provide for some method, such as an earn-out strategy, that allows physicians to work their way out of the practice. "Both parties should be able to part on a friendly basis if the business plan doesn't work."

Harrington said it's preferable for the

hospital to own the practice on a transitional basis if possible. "I'd like to see the hospital put the doctors on an employee stock ownership program giving the physicians the ability to earn their way out of it over a period of time. At the end, if the doctors' practices have met targets, they can be out of the relationship. This arrangement is a tool to help the hospital and medical staff through these transitional times."

Gorey also advised physicians to have escape clauses written into contracts, so they can re-establish private practice without burdensome restrictions.

In Illinois, two lawsuits have involved contractual noncompete clauses that restricted physicians' ability to practice in certain geographic areas if the contracts were terminated. Those cases have also centered on the larger issue of whether hospitals may employ physicians without violating the state's corporate practice of medicine doctrine. In the case of Holden vs. Rockford Memorial Hospital, the trial and appellate courts ruled in favor of a ban on the corporate practice of medicine. The court addressed issues such as what constitutes the practice of medicine. According to the attorney for John Holden, MD, the hospital "had such control over him that it considered his patients to be hospital patients."

In Berlin vs. Sarah Bush Lincoln Health Center, the Illinois Supreme Court is considering whether the contract between a physician and a hospital was enforceable or whether it violated the ban on the corporate practice of medicine. Lower-court decisions found that the contract was unenforceable. ISMS submitted amicus curiae briefs supporting the physicians in both the Holden and Berlin cases.

DESPITE THE LEGAL ISSUES and caveats, for some physicians, being employed by a hospital can work well. Rockford family physician William Kobler, MD, has been an employee of the Order of St. Francis Medical Group, the physician arm of OSF Health Care System, for more than three years. "By being part of an organized group — whether that's part of an organized medical group or a vertically integrated system — you have better ability to set up a working relationship with managed care organizations," he said.

The employment arrangement with the hospital has made it easier to meet regulatory requirements economically and allowed for a better lifestyle, said Dr. Kobler, who is also vice speaker of the ISMS House of Delegates. He said that lack of autonomy is not a problem. "We have a fair degree of responsibility and authority within our own practice." Physicians are asked what they want included in the budget, he added.

Dr. Kobler suggested that physicians considering selling their practices talk to other physicians who have sold their practices to the same hospital. "Find out how autonomous they are with regard to the practice of medicine." He also advised finding out the hospital's mission. "Is it to take care of patients or just to gain market share?"

Finally, make sure the relationship is a true partnership, Dr. Kobler recommended. "In this day and age of chaos in the medical delivery system, the idea of having a group of people around you who are committed to the same goal and working toward the same end can be supportive personally and professionally." ■



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REPORT for Illinois Physicians

1997 BCBSI/NAEPP Asthma Guidelines – plus Highlighted Differences from 1991 Guidelines

GUIDELINES FOR THE DIAGNOSIS AND MANAGEMENT OF ASTHMA

- The National Asthma Education & Prevention Program (NAEPP) Guidelines for the Diagnosis and Management of Asthma are recommended for use in caring for patients with or considered at risk for asthma.
- In summary, diagnosis and treatment should include, as necessary, the use of:
 - Peak Flow Meters** for the evaluation of asthma severity;
 - Anti-inflammatory Agents** for patients with any class of persistent asthma (symptoms more than twice a week, or nighttime symptoms > twice a month);
 - Environmental Assessment** for patients with histories suggestive of an allergic component;
 - Patient Education** to heighten awareness of the importance of self-management in this chronic disease; and
 - Influenza Vaccinations** annually, for patients with any level of persistent asthma.
- Key differences between the 1997 update and the original 1991 version of the guidelines relates to severity classifications, which have been changed from the previous mild/moderate/severe to the following 4 severity levels, based on symptoms before treatment:

Mild Intermittent Asthma –	Symptoms ≤ twice a week Nighttime symptoms ≤ twice a month
Mild Persistent Asthma –	Symptoms > twice a week Nighttime symptoms > twice a month
Moderate Persistent Asthma –	Daily symptoms Exacerbations ≥ twice a week Nighttime symptoms ≥ once a week
Severe Persistent Asthma –	Continual Symptoms Limited physical activity more frequent daytime or nocturnal exacerbations

(Presence of any one of the features of severity is sufficient to place a patient in that category. An individual should be assigned to the most severe grade in which any feature occurs. These classifications define the need for the escalation of drug therapy in a stepwise manner – see References.)

- Copies of the full report may be obtained through the NAEPP, P.O. Box 30105, Bethesda, MD 20824-0105, or by calling (301) 251-1222. A shorter, Practical Guide is in development, and should be available in late 1997. These contain many useful details – physicians are urged to become familiar with them.

References:

National Asthma Education & Prevention Program, Expert Panel Report II: "Guidelines for the Diagnosis and Management of Asthma." Office of Preventions, Education, and Control; National Heart, Lung, and Blood Institute; National Institutes of Health; Bethesda, Maryland, 20892. February 1997. U.S. Department of Health and Human Services, Public Health Service, National Institutes of Health.

NAEPP, National Institutes of Health, 1997. Differences between the 1991 Expert Panel Report and the 1997 Expert Panel Report II: Guidelines for the Diagnosis and Management of Asthma, April 1997.

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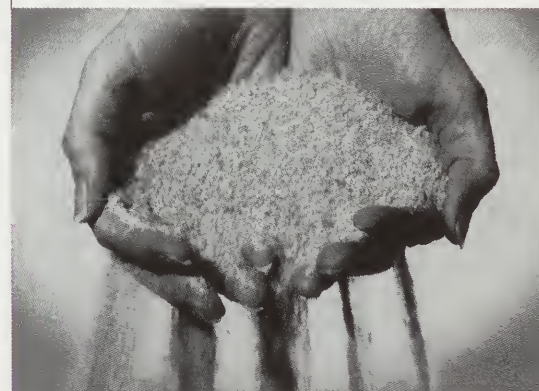
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Consumer groups

(Continued from page 1)

they support H.B. 626 because it prohibits gag clauses and practices. "Every patient should have the opportunity to learn about all the options available for their care, and physicians should be able to discuss a recommended treatment plan without fear of retribution," said Terry Light, MD, a representative of the Illinois Coalition for Patient Access and Choice.

Opponents of comprehensive managed care reform argued that enacting "anti-managed care" legislation would hurt Illinois businesses by reducing their flexibility in contract negotiation.

Sen. Denny Jacobs (D-Moline) explained that no one on the subcommittee opposes managed care. "We're here to react to complaints, because the managed care marketplace is not taking care of itself. We're not looking to pass anti-anything. We're looking to pass pro-quality, pro-consumer legislation."

Jacobs questioned claims that managed care provides quality health services for less money. He said that he has learned to doubt sales pitches that promise something will be better for less money. "Somewhere I lose something. That's what we're trying to figure out. What do I lose? Is it quality? Is it choice?"

Conrad Meier, a consultant for the Palatine-based Heartland Institute, also challenged some of the opponents' arguments: "Americans have been misled to believe that managed care is the most popular form of care and that the cost of health care is less today." In this case, popularity is defined by the number of enrollees in managed care plans, he said. But managed care is often the only option offered by employers.

Meier said a lower inflation rate is not exclusive to health care and is temporary. "By managed care's own admission, plans have wrung out just about all the savings from the administrative side of health care and expect 5 to 10 percent premium increases in the near future." ■

IDPA accepts

(Continued from page 1)

month extension and a Nov. 1 starting date for their new contracts, which will be in effect for two years or until MediPlan Plus is implemented.

With the qualified bidders having been notified, IDPA is expected to complete negotiations for the new contracts by Aug. 25, Hovanec said. Still to be negotiated are the fees IDPA will pay for services, legal issues like reporting requirements and penalties for failure to comply, and the geographic area to be covered by each HMO.

Physicians will still be allowed to see Medicaid enrollees on a fee-for-service basis.

This voluntary program is not related to MediPlan Plus, the state's proposed mandatory managed care program. Any contracts approved as part of the voluntary program will be terminated when MediPlan Plus starts, Hovanec said.

Physicians who currently contract with American Health Care Providers, Maxicare Health Plans of the Midwest and Unity HMO of Illinois – the three HMOs that do not meet all the state's requirements and may amend their proposals – may get notices that the plans' IDPA contracts are about to expire, Hovanec said. ■

MediPlan Plus

(Continued from page 1)

The delay was caused in part by the amount of paperwork that HCFA must review, Hovanec said. "The documentation behind MediPlan Plus is massive. By the time all is said and done, it's about 12 inches of reading in very small print. It took a long time for [HCFA] to go through everything to satisfy themselves that we had thought everything out."

IDPA has received HCFA's comments on all of the MediPlan Plus original documentation, such as the operational

protocol and enrolled managed care provider handbook, and is working to revise the documents to address HCFA's concerns. Revisions include making all policies and procedures consistent with state laws and regulations and ensuring that special-needs patients get the care they need. "They want to make sure that no one who has a serious condition and is receiving treatment will be torn away from that treatment because they failed to fill out the card right and defaulted into some other medical system that can't meet their needs," Hovanec said.

HCFA also wants IDPA to clarify a

provision permitting physicians to disenroll Medicaid clients in certain situations, such as when recipients choose specialists who do not treat the patients' conditions or when patients are verbally abusive to staff or other patients. "HCFA wants assurances that that will not lead to discriminatory practices," Hovanec said.

IDPA will continue to submit documents to HCFA for its review and approval. The department also wants to select a quality assurance organization through a competitive bidding process, according to the application to HCFA. "It's full-speed ahead," Hovanec said. ■

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09/03/97



Making sense of
accreditation
'alphabet soup'

PAGE 7

Illinois Medicine

ILLINOIS STATE MEDICAL SOCIETY • AUGUST 29 1997

When adults
can't make
adult decisions

PAGE 6

Congress approves federal Medicare reforms

BUDGET: Changes expected to save an estimated \$116.4 billion during the next five years. BY JANE ZENTMYER

[WASHINGTON] When Congress finally compromised on the 1998 federal budget in late July, the agreed-upon Medicare reforms included a provision the AMA worked hard to get: a one-year delay to implement new practice expense values. That provision is just one of many in the 550-plus-page bill that affect physicians. Of the \$116.4 billion to be trimmed from Medicare during the next five years, \$5.3 billion will come from physician services.

"This is a difficult agreement that has to be viewed as only a tentative first step toward preserving Medicare," said AMA President Percy Wootton, MD. "Much more clearly needs to be done, and we will continue to work with members of Congress and the administration to make sure Medicare beneficiaries, as well as all Americans, receive the best possible care."

The budget reconciliation measure, which President Bill Clinton signed Aug. 5, delays implementation of new resource-based practice expense values until 1999. During the one-year delay, the U.S. Health Care Financing Administration must develop new practice expense values that take into account such factors as staff, equipment, supplies, actual data

on equipment utilization and consultations with physician organizations about methodology and data, according to an ISMS analysis.

The new values must be reported to Congress by March 31, 1998, and must be published by May 1, 1998, according to the analysis. They will be phased in over four years beginning in 1999. The ISMS-supported delay will give physicians time to assess their practices and make necessary changes, according to John Schneider, MD, chairman of ISMS' Third Party Payment Processes Committee. "The challenge that it poses for physicians will be that they'll need to become more aware of how they can minimize the practice expense in their offices and still provide the services that they need to provide."

The budget reconciliation bill also includes a compromise measure for primary care physicians, Dr. Schneider said. It calls for shifting a maximum of \$390 million from procedural services to primary care office-based services in 1998. To do that, the bill limits practice expense relative values to 110 percent of work relative values - a reduction from the current limit of 126 percent. As a result, payment for office visits will increase about 6

percent, according to the ISMS analysis.

The practice expense value is just one of three factors used to calculate physician payments, accounting for about 41 percent of the total Medicare reimbursement, an ISMS analyst said. The value associated with work expense is another 45 percent of the payment, with the remaining portion attributed to liability expense. Each factor is adjusted to reflect operating costs in various regions of the country.

Once a total value incorporating these three factors is reached, it is multiplied by the conversion factor to reach the dollar amount Medicare will pay physicians. Although the current conversion process requires dif-



Dr. Schneider

ferent factors for primary care, surgical and other services, the budget reconciliation bill reduces the number of conversion factors from three to one. By switching to a single conversion factor, payments to primary care services will be cut 3.8 percent and surgical services cut 11.9 percent, according to the ISMS analysis. The single conversion factor will be implemented in January 1998.

Future calculations of the conversion factor will also change. The law replaces the "Medicare volume performance standards" now used to update the conversion factor with the "sustainable growth rate." The net effect of this change will be to slow the conversion factor's growth rate and, subsequently, curb reimbursement for physician services, the ISMS analyst explained.

(Continued on page 11)

Department of Insurance releases data on complaints against HMOs

INSURANCE: Consumers can use ratings to help them choose plans.

BY JANE ZENTMYER

[SPRINGFIELD] Are your patients curious about the quality and reputation of their HMOs? They might want to check the 1996 complaint figures for 40 of the state's HMOs that were released June 24 by the Illinois Department of Insurance.

"It's an additional tool for consumers when they're shopping for insurance policies. It gives them a benchmark of [HMOs'] claims handling or policyholder services," said IDOI spokesperson Nan Nases. "We always caution people not to make a decision based solely on the complaints, but that is one of the factors they can look at."

Twenty-five of the 40 HMOs had a total of 703 complaints filed against them; the remaining 15 had none.

The IDOI used a formula

that figured the number of complaints filed against HMOs for every 10,000 enrollees. The lowest rating for an HMO that had complaints filed against it was 1.21 for Urbana-based Health Alliance Medical Plans. The highest ranking, 13.56, went to American Health Care Providers in Matteson.

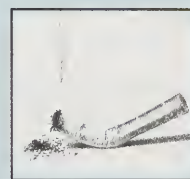
"The [rating] was developed with our actuary to be weighted so the size of the HMO is inconsequential," said David Grant, IDOI's health care coordinator. The numbers exclude the HMO's Medicare and Medicaid enrollees, he said, because

the state agency does not have the authority to collect or handle those complaints. Also omitted from the IDOI's ratings are complaints that HMOs address through their own internal and external grievance processes, Grant said.

After American Health Care, the HMOs with the highest complaint ratings were Compass Health Care Plans, Rosemont, 12.3; Maxicare Health Plans of the Midwest, Los Angeles, 11.68; Mercy Health Plans of Missouri, St. Louis, 9.92; Health Direct Insurance, (Continued on page 11)

INSIDE

**AMA backs
modified tobacco
settlement**



PAGE 2

**McLean County
doctors form
physician
organization**

PAGE 3

DEPARTMENTS

**Malpractice
Roundup.....6**

Classifieds9



Brian Warling

WIELDING A HUGE SCALPEL, students at Loyola University's Stritch School of Medicine prepare to cut the ribbon on a new \$32 million medical education building on the Maywood campus. The ceremony was held July 31.



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ISMS fund lends a helping hand

Physicians and their families can receive some extra help during difficult times. BY JANE ZENTMYER

When a teen-age boy became a quadriplegic in an auto accident, his family's finances deteriorated. The mother – a widow whose husband had been an ISMS member physician – turned to the medical community. "The assistance from ISMS not only helped with some of the financial burden, but it let us know that we had moral support from our own – the medical family," the woman said.

Established in 1940, the Illinois State Medical Benevolent Fund Inc. provides modest financial assistance for members or their families who have fallen on hard times. In its 57-year history, the fund has helped an estimated 200 member physicians and their families.

"Life treats us all differently, and adversity – life, health or financial setbacks – can injure anyone," said Richard Geline, MD, immediate past chairman of the ISMS Finance and Medical Benevolence Committee. "That's what this fund is for – to help physicians and their families."

The committee reviews applications individually and makes decisions based on each set of circumstances, Dr. Geline said. One woman, for example, asked for assistance after her husband, who suffered from Alzheimer's disease, died, and she was left to care for a child who had physical and emotional impairments.

Although early recipients were given monthly stipends, in 1985 the committee opted for one-time, lump-sum distributions instead.

Confidentiality is guaranteed, Dr.

Geline said. The committee may ask applicants to explore options through other philanthropic organizations before it makes a decision. The amount of the assistance is based on applicants' circumstances and the availability of funds, Dr. Geline said.

"We have helped an awful lot of people who have gone through difficult times whether it's because of an illness or other problems," said Nancy Hoffmann, the ISMS Alliance liaison to the committee. The Alliance's contributions have been important to the fund. For

many years, a dollar from the dues of each Alliance member was earmarked for the benevolent fund. County alliances have raised money for the fund as well. "It's our show of support [for the medical community]," said ISMS Alliance President Julie Ringhofer.

The benevolent fund is not commingled with the Society's finances, Dr. Geline said. It is self-supporting because the interest earned from existing funds pays for the assistance given.

Dr. Geline added that despite the myth that all physicians are wealthy, the benevolent fund helps those with legitimate financial need. Physicians "are normal people with all the strengths, weaknesses and frailties of [other] people and, as such, from time to time there may be a case arising where things aren't so favorable."

For more information, call ISMS at (800) 782-ISMS or (312) 782-1654 and ask for the benevolent fund. ■

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John McNulty

ATTENDEES of the Sixth National Alzheimer's Disease Education Conference look at a quilt displaying the photos of victims of the disease. The conference was sponsored by the Alzheimer's Association and was held in Chicago July 20-23.

AMA backs tobacco settlement but with changes

PUBLIC HEALTH: Organization works to build consensus.

BY JANE ZENTMYER

[CHICAGO] Following a review by its task force, the AMA announced on July 31 that it supports the proposed settlement to the legal dispute between the tobacco industry and 40 states as long as two key provisions are met: The federal Food and Drug Administration must be given the same authority over tobacco products that it has over other drugs and devices, and the fines against the tobacco industry for missing its goals to reduce underage smoking must be increased.

The settlement mandates that underage tobacco use must drop by 42 percent in five years, 58 percent in seven years and 67 percent in 10 years. If those goals aren't met, the industry must pay \$80 million annually, up to a \$2 billion maximum, for each percentage point off of the targeted amount, according to Illinois Attorney General Jim Ryan. The AMA said it wants to increase the fees for missing the targets by as much as \$423 million for each percentage point.

The AMA will also work to build consensus among the nation's public health groups, which have taken conflicting stances on the proposal. "The AMA's commitment is to help organize a broad-based public health coalition that will engage leaders in Congress and the White House on behalf of America's young people who, for too long, have been seduced by cigarette-makers," said Randolph Smoak, MD, vice chairman of the AMA Board of Trustees. As this issue of Illinois Medicine went to press, the AMA was meeting with public health groups.

Congress and President Bill Clinton still must approve the settlement, and the AMA plans to lobby vigorously for the changes its task force recommends in a 45-page report. "The danger is that once the tobacco industry gets the relief it seeks, there is no incentive for them to cooperate further," said Richard Corlin, MD, speaker of the AMA's House of Delegates. "We have to get it right the first time."

As proposed, the \$358 billion settlement would compensate states for the public funds used to treat smoking-related illnesses. Ryan filed suit in November 1996 to recoup what he estimated to be

about \$2 billion that Illinois' Medicaid program has spent on treating smoking-related illnesses since 1980.

The settlement would generate between \$4.5 billion and \$7.5 billion per year in funding for public health programs, making it a more beneficial arrangement than continuing litigation and piecemeal legislation, Dr. Corlin said.

Ryan said the proposed agreement doesn't offer blanket immunity from prosecution to tobacco companies and their executives. Current private lawsuits would still be pending against the companies, but the settlement would not allow any punitive damages to be collected from those individual private lawsuits because it calls for a payout of \$50 billion in punitive damages over 25 years, according to Ryan's office. If the settlement is enacted, the tobacco industry's conduct thereafter could still be the basis for lawsuits filed and punitive damages collected by individuals. Class action lawsuits against the tobacco companies would not be allowed, though.

The AMA's task force also "strongly recommended" several other changes to the settlement. The report called for increasing the per-pack cost hike to \$1 from 62 cents. It also said the FDA should be given authority to progressively tighten the underage smoking targets after the 10-year period in the settlement. Clarification is also needed to ensure that states and local governments can impose civil sanctions on tobacco retailers beyond the federal minimum. ■

FAT CITY

Top 20 cities with the highest rates of obesity for adults age 20 to 74, 1990 and 1993*

Rank	Metro	Percent obese
1	New Orleans	37.6
2	Norfolk, Va.	33.9
3	San Antonio	33.0
4	Kansas City, Mo.	31.7
5	Cleveland	31.5
6	Detroit	31.0
7	Columbus, Ohio	30.8
8	Cincinnati	30.7
9	Pittsburgh	30.0
10	Houston	29.2
11	Philadelphia	29.1
12	Milwaukee	28.8
13	Buffalo, N.Y.	28.4
14	Sacramento, Calif.	28.2
15	Dallas-Fort Worth	27.5
16	Portland, Ore.	27.2
17	Chicago	27.1
18	New York	27.1
19	Miami	27.0
20	Baltimore	26.4

*Cases for these two years were combined.

Sources: Coalition for Excess Weight Risk Education, Washington, D.C.; National Center for Health Statistics

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McLean County doctors form physician organization

MANAGED CARE: Restructured venture seeks capitated contracts.

BY JANE ZENTMYER

[BLOOMINGTON] In 1992, a group of physicians in the Bloomington-Normal area decided that instead of just watching the federal government and managed care intrude into their practices, they would create the McLean Area Medical Association to take control of their future.

"This group got together and said that if we can speak with one voice, [it will be] a really loud voice," said John Wieland, MD, MAMA's vice president and a member of its negotiating committee. "We didn't have any idea what would happen, but we knew that we were all on the same page."

MAMA began as a nonprofit physician organization with more than 100 local primary care physicians and specialists. Annual membership dues provided the organization's only source of revenue, said Robert Chapman, MD, MAMA's executive director and president of its board of directors. In the beginning, the organization negotiated only fee-for-service contracts.

"The goal of MAMA was to try and prevent the community from becoming fractionated, like it seems to be in larger areas such as Chicago, to protect patients from things like gag clauses and hold-harmless clauses and to make insurance companies responsible for their [utilization review] decisions," explained past President Stephen Matter, MD.

Members of MAMA decided that to be competitive and accept capitated contracts, the organization would need capitalization, which would help fund the necessary information systems. In January, MAMA reorganized as a for-profit organization. Each share of the group's Class A stock, available only to physicians, sold for \$5,000, Dr. Chapman said. Physicians who chose not to buy stock but wanted to remain on the panel could become physician providers by paying a \$1,000 annual fee. Class B stock was offered to nonphysicians at \$2,500 per share. Unlike the Class A stock, the Class B stock doesn't provide governing or voting rights.

As of mid-August, 70 physicians had purchased Class A stock; 15 had chosen to be providers; and one had bought Class B stock, according to Dr. Chapman. Several applications for each option are pending, he said. Those physicians who purchased stock invested in their practices, Dr. Chapman explained. "As the organization evolves and does what we want, it helps everybody." MAMA is working to increase its market share through contracting and is reducing member expenses through group-purchasing plans and discounted rates for malpractice insurance, Dr. Chapman said.

Using the capital raised from the stock sale, MAMA expanded its staff and started researching information systems. "We foresee continued growth, development of medical management and possible partnership with employers and investors in the community," Dr. Matter said. The organization is now

negotiating for capitated contracts and has at least five fee-for-service contracts, according to Dr. Chapman.

The stock offering reduced MAMA's base of primary care physicians because most of the local hospitals, which employ most of the primary care physicians in

the area, refused to pay for doctors' participation in MAMA after the conversion to a for-profit entity or discouraged primary care physicians from participating. The organization is working to expand its primary care base as soon as possible.

As the organization evolved, consultants helped with business and legal advice. "I'm trained in gastrology, but until we set up this [organization] I had no idea what a hold-harmless clause was," Dr. Matter said.

It's imperative that all doctors involved in a physician organization have the same goals, Dr. Wieland said. "If only half want to preserve fees or

not lose ground in the changing market, your organization is doomed to failure. If you have an attitude that medicine is changing and we're not sure where that's going to lead us but we'll be in there swinging in terms of advocacy for patients, the rest will take care of itself."

Physician leadership is crucial to an organization's success, Dr. Wieland said. "If the people who are leading the medical community stand up and say, 'We think we should all follow this lead,' [the venture] is going to be successful," he said. "We were fortunate that we had this from the outset." ■



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REPORT for Illinois Physicians

MEDICARE PART B

DOCUMENTATION GUIDELINES

FOR EVALUATION AND MANAGEMENT (E/M) SERVICES

These guidelines were developed jointly by the American Medical Association (AMA) and the Health Care Financing Administration (HCFA). They have been recently revised, adding documentation requirements for single organ system examinations. They were recently mailed to all Illinois providers who bill Medicare for E/M services, as a service of the Illinois Medicare Part B carrier.

The mutual goal of the AMA and HCFA is to provide physicians and claims reviewers with advice about preparing or reviewing documentation for E/M services. In developing and testing the validity of these guidelines, special emphasis was placed on assuring that they:

- are consistent with the clinical descriptors and definitions contained in CPT;
- would be widely accepted by clinicians and minimize any changes in record-keeping practices; and
- would be interpreted and applied uniformly by users across the country.

This edition contains a substantial amount of new material and a number of significant revisions in material that appeared in the first edition. Because of the extensive changes, the section on examination should be read in its entirety. In this edition:

- The content of general multi-system examinations has been defined with greater clinical specificity.
- Documentation requirements for general multi-system examinations have been changed.
- For the first time, content and documentation requirements have been defined for examinations pertaining to ten organ systems. The content of these examinations was developed with the assistance of representatives from the specialties that frequently perform these examinations.
- Several editorial changes have been made in the definitions of the four types of examinations. This text also appears in CPT itself in the section headed "Evaluation and Management (E/M) Services Guidelines," but the revisions will not appear there until the 1999 edition of CPT.
- The definition of an extended history of present illness has been expanded to include information about chronic or inactive conditions.

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EDITORIAL

What's best for Illinois

On a recent television news program about the need for tort reform, the anchorperson recalled his personal experience in having been sued. He even showed the many, many boxes full of documents produced during discovery – material that had taken more than a year to amass and be reviewed. Then he talked about the time – several years – and the money spent to resolve the suit and the toll it took on him and his family. Although he won the case, his legal fees were enormous. The program emphasized that even if we have never been sued ourselves, we have all been personally affected by out-of-control litigation – through higher costs, fewer products and services and less personal freedom – and that we desperately need tort reform.

Fighting for tort reform has been a primary activity for ISMS and ISMIE for 20-plus years. The efforts of both organizations were critical in passing the 1995 tort reform law. The constitutionality of that law is now being considered by the Illinois Supreme Court, and on Aug. 1, ISMS, the Illinois Civil Justice League and other organizations filed amicus briefs supporting the law. A key issue, according to the ISMS brief, “is the right of the General Assembly to determine the public policy of the state of Illinois.” Attorney General Jim Ryan wrote in his brief, “Although the plaintiffs ridicule the notion, the remedy for their complaints lies with the General Assembly.”

In the case being used to determine

constitutionality, the plaintiffs’ supporters argued that women and minorities are disproportionately harmed by a cap on noneconomic damages, since their wages, and therefore their economic damages, are often lower. Ryan stated: “The purpose of the civil justice system is to adjudicate disputes and compensate injuries, not to right social imbalances through the redistribution of wealth.”

Responding to charges that the law was designed to benefit a particular group, ICJL wrote that the legislation “affects all potential personal injury plaintiffs and defendants equally, because none of us knows whether tomorrow we will be injured parties or targets of lawsuits claiming that we are responsible for the injuries of others.”

In a joint brief, the Illinois Hospital and HealthSystems Association and the Metropolitan Chicago Healthcare Council outlined substantial evidence that the General Assembly didn’t act impulsively in passing tort reform. They cited a Harvard study that found that five out of six mal cases involved no evidence of negligence and a study reported in the New England Journal of Medicine that showed that claims are usually driven by the severity of patients’ injuries, not negligence.

We can be proud of ISMS, ICJL and all the other organizations that submitted briefs supporting those reforms that state legislators and their constituents decided were best for Illinois.

PRESIDENT'S LETTER

Let's find out about alternative medicine

Jane L. Jackman, MD



Let's talk to our patients about their fears and expectations and remind them that we are partners in their health care.

There's a new type of medicine out there: Everyone's talking about it; managed care companies are embracing it; and we are told that at least a third of our patients are using it – and not telling us. It's called alternative medicine. Whether it comes in the form of shark cartilage, DHEA, vitamin therapy, Echinacea or ginseng, chances are that large numbers of our patients are using it, and we don't know it.

After all, this new medicine is so anti-establishment and natural that our patients fear that we might be skeptical and overact if we found out what they were taking. Of course, then we would become part of the “conspiracy” to hide the “truth” from the American public.

Nutritional supplements – vitamins, minerals, herbs and amino acids – are a \$3 billion per year industry in the United States. Last year, 60 million adults in our country spent an average of \$50 per person on them. Unfortunately, these supplements are considered a food by the Dietary Supplement Health Education Act of 1994 and are largely unregulated by the government. Their manufacturers are prohibited from telling consumers much about what they are supposed to do, and they can't make health or therapeutic claims about their products. Although undoubtedly some nutritional supplements appear effective against disease, others can be dangerous – for example, Ma Huang – and many more are scientifically unproven in effectiveness.

What is driving this trend toward “natural medicine”? Is it perhaps the surrogate for a medical establishment that has become less high-touch and more high-tech, that has no easy answers for so many chronic illnesses and that has less time for sitting down and listening to patients? No wonder alternative medicine is so popular: It offers simpler therapeutic choices and a feeling of control over one's own illness. The fact is that often we don't have good answers for a lot of what ails our patients.

One of my patients with recurrent breast cancer recently refused

chemotherapy and radiation in favor of “nutritional therapy,” which, she explained, builds up the immune system while the other methods break it down. This caused me to start asking most of my patients if they are using alternative therapies. The answers I've received have been eye-opening, with many patients who are using conventional medicine telling me that they are also using herbs and vitamins, since “it can't hurt, and it might help.”

Given that alternative medicine is such a widespread, growing trend, what should we do about it? If you are like me, you probably know very little about it, so the first step is to educate ourselves about what is out there. We definitely need to know what is acceptable or harmless and what is potentially dangerous. And since snake oil still seems to attract the American public, we should find out what is expensive and what is exploitative.

The next time you're in a bookstore, look at the books and magazines our patients may be reading – Prevention, Men's Health, even Cosmopolitan – to find out what is being touted as the miracle cure of the month. Most important, let's talk to our patients about their fears and expectations and remind them that we are partners in their health care. Patients today want advice on how to stay healthy, so we need to stress preventive medicine or they will look elsewhere. The presidential commission on dietary supplements and labels recently said that more government oversight of these products is needed to protect the public, and I agree.

The government and several medical schools are now studying the value of alternative medicine, so it seems it is here to stay for a while. Who knows, maybe our medical schools in the next century will routinely require classes in botany, nutrition and acupuncture. If that seems a little far-fetched, the next time you're in a drugstore or supermarket, glance at the rows of nutritional supplements – and then start asking your patients which ones they're taking!

GUEST EDITORIAL

Why aren't cigars shunned like cigarettes?

By Ellen Goodman

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Funny thing about smoke. You try to get a lid down on the stuff, and it drifts out the edges.

Here we are at a peak moment in the anti-smoking movement. RJR has just given Joe Camel the heave-ho and sent him to the big ad desert. The government is into the second round of negotiations for a stiffer tobacco deal. Flight attendants have begun a \$5 billion class action suit against secondhand smoke.

Just when it's getting safe to take a long breath of fresh air, there's a whiff of something newly noxious.

Sniff, sniff. What is that odor coming from yet another smoking section? Sniff, sniff. Could it be a cigar? Could it be 4.4 billion cigars, or roughly 20 percent more than last year?

And could it be that while the smoking police were tracking down the hip and glam marketing of cigarettes, the old stogie was being transformed into an elegant accessory for the eager mouths of the young masters of the universe?

From time to time this year I smelled the return of the cigar. I learned about upscale cigar bars and restaurants where men and women actually line up to get into a smoke-filled room. I learned about cigar societies and cigar tastings.

In search of the full flavor of the image revival I even leafed through the glossier-than-thou, 434-page magazine called *Cigar Aficionado*. I discovered a campaign that reeks of money as much as tobacco leaf.

Glance at the August issue in which supermodel Claudia Schiffer holds a fully lit and pricey stogie midway between her mouth and her cleavage. Cigars are being "positioned" with ads for martinis and MGs. The cigar is sold among upscale power toys: fireplaces, leather chairs, smoking jackets and golf clubs. There's even a Gulfstream jet ad – for the cigar smoker who has everything but his own smoking section.

There is something astonishingly retro in this revival. My favorite cigar ad is almost a parody. One Alpha male is telling another how he recruited a new star for the law firm. "I told him that except for the age difference we were very much alike," says Alpha One. "...We went to the same prep school, same law school, the squash, the golf, both married our college sweethearts, you know." The clincher? "It turns out we smoke the same cigar."

Male bonding through cigar smoking? Is there something symbolic going on here? Or should we remember what Freud said, that sometimes a cigar is just a cigar? Especially since it's being marketed to women as well.

In any case, it is startling to see that while the health spotlight has been on cigarettes, the Havana craze has gone on unabated. It's been ignored largely because cigarettes are considered worse

for your health, more addictive and more adult. But one average cigar has the nicotine of four or five cigarettes and as much tobacco as 15. Someone who smokes one or two cigars a day has a much greater risk of cancer of the mouth, throat and esophagus than a nonsmoker.

Just weeks ago, a surprised and alarmed Centers for Disease Control and Prevention reported that teens are experimenting with cigars at a much higher rate – one out of four had smoked a cigar last year – than anyone knew.

Now at last the health activists, who were caught napping when chewing tobacco became a young and deadly habit a few years ago, are responding. The team of C. Everett Koop and David Kessler wants cigars included in the tobacco deal. Lawmakers in Massachusetts want labels on cigars like those on cigarettes.

There are also some de-glamming, de-



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chicing ads you'll never see in *Cigar Aficionado*. One from San Francisco shows a woman tossing a stogie on the sidewalk and a man picking it up with a pooper-scooper. The bottom line: "Cigars, they look like what they smell like. Don't put them in your mouth."

Another one from the American Cancer Society has the full glitzy photo of a fancy, high-end cigar cutter not far from a burning cigar. The message in the cutter: "You can also use it to cut the tumor off

your lip." Not subtle, but you get the idea.

Nevertheless, the tobacco companies' resilience is truly astounding. The rise of the cigar from the ashes of its own image is just another example.

Back in the mid-19th century, spitting in public was still acceptable behavior for genteel folk. I always thought that smoking would go the way of spitting, shamed out of public. But now the humidor is making a pricey comeback. Watch out for the first sign of a new spittoon.

GUEST EDITORIAL

Just a few unflattering truisms about lawyers

By Phil Ponce

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According to Mark Twain, "Everyone is a moon and has a dark side which he never shows to anybody." Actually many of us might have enough dark sides to use up a good chunk of the solar system.

We carry little secrets we hide from the world. For example, someone whose picture one might very well find close to these words carries with him the following unseemly baggage: an attraction to a well-known lifestyle maven that goes well beyond her ability to make charming holiday wreaths; a lingering, embarrassing and irrational loyalty to a volatile red-sweater-wearing college basketball coach; the habit of playing a certain rock song in his head when he wants to tune people out. Poor guy.

But enough about him. There's one fact about me I seldom trumpet: before entering journalism, I not only went to law school, I actually practiced law. I was a lawyer. There – I said it. It's the first step toward recovery.

Sure, the landscape is populated with lawyers who are on the side of the angels, who fight the good fight and use their skills for the betterment of humankind. And there are legions of lawyers who help individuals, groups and companies resolve honest differences in a logical way. God bless those practitioners.

But as the saying goes, if you're a hammer, everything starts looking like a nail. And for some lawyers, it seems, everything can look like a lawsuit.

A recent example is the well-publi-

cized lawsuit brought by a former candidate for the U.S. Senate who is a successful personal-injury lawyer to boot. Did he sue a bad-guy polluter or a drunken driver? No, he sued a kids' baseball league. The charge? The league was unfairly keeping his 9-year-old son from playing on the team of his son's choice. The lad could play, mind you, but only for the team to which the league felt he had originally committed. According to the league, once the youngster committed to one team, he couldn't switch. Otherwise, kids – and especially their parents – might jockey for the best teams.

Ultimately, the one-time would-be senator from the great state of Illinois announced he was dropping the suit because all the publicity was bad for the kids in the league. (Clearly, the publicity was not reflecting poorly on him.) Thank goodness. Think of the precedent it might have set for other parent-lawyers. Did Snookums not get the lead in the fifth-grade production of the *Velveten Rabbit*? Don't worry, sweetie. Mommy will sue! Did Peaches' Crayola masterpiece not make the hallway bulletin board? There, there. The picture lady will fry!

It's the eye-rolling lawsuits that make lawyers – and the legal profession – look silly and keep some of us ex-lawyers semiclosed. An outstanding trial judge who teaches courtroom skills to law students once said that when someone says he or she is a law student, relatives and friends tend to be pleased and impressed. But when they say they are lawyers, the reaction changes. Why?

It may have to do with the fighting.

Society wants it both ways. It wants lawyers who can fight on cue but who can also keep that impulse in check. It's like wanting your pit bull to guard against intruders but not to maul the kid who chases a ball into your yard. Some pit bulls can't tell the difference.

The fighting business played a big part in my leaving the law (that, and the universal love and regard people have for journalists). I went to law school straight out of college and was too dense to figure out that a lot of the practice of law involved fighting. And once I graduated, I thought I was stuck.

"Honey, I'm home."

"How was your day?"

"Great! I fought!"

"How nice for you."

This went on for about seven years until I took myself out of the ring. One job lasted half a day. It was with a legal aid organization. After doing "intake" with a prospective client I suspected of committing child abuse, I was so depressed I got her file in order, sent it to a senior attorney and then very conspicuously announced I was leaving for lunch. "I am going out to eat now!" I yelled at a staff startled by my tone and volume. I said it again, slowly, "I-am-going-now." The office receptionist gave me a funny look. I never returned. Years later I learned that for some time afterwards people in the office would occasionally speculate, "What do you think he's eating now?"

I don't mention those law school and lawyering days much anymore. I consider it my lost decade. It was a little like being lost in space. Or on the dark side of the moon.

Coming soon:
Ending the
physician-patient
relationship

ISMIE Update

When adults cannot make adult decisions

How would you handle these situations in which patients couldn't make judgments about their care? BY MINDY KOLOF

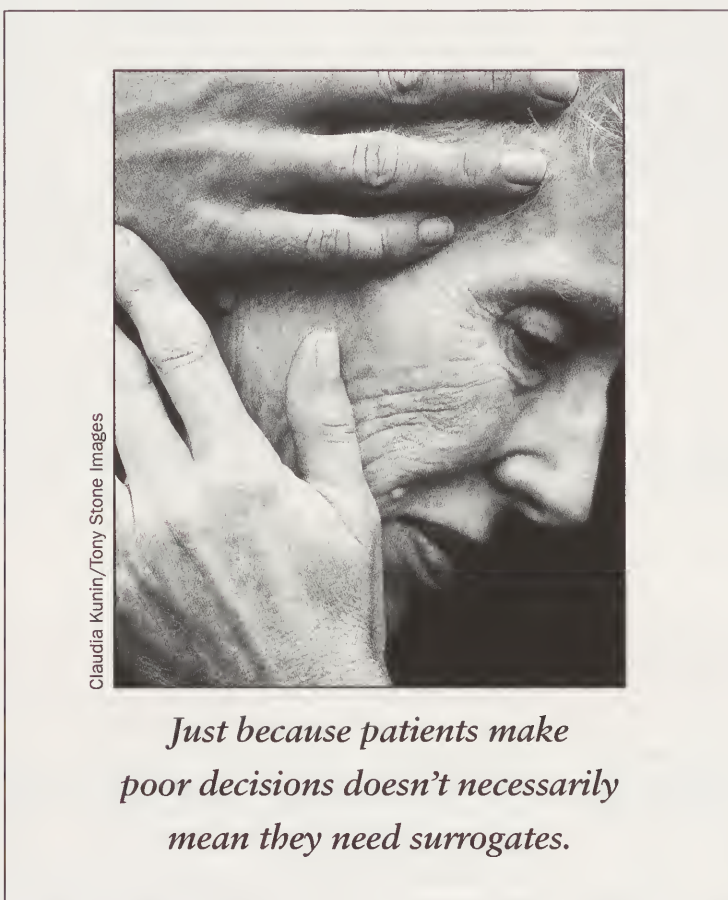
Your patient uses a ventilator as he recuperates from surgery, but his two adult children are encouraging you to remove the device immediately. Although he is temporarily incapacitated and can't make his own decisions, you feel confident he will have a good quality of life after the ventilator is removed in 48 hours. But the patient's children insist that he be taken off the ventilator immediately, asserting, "Dad always told us he'd rather die than be on a ventilator." The man has no living will and no power of attorney. What do you do?

That case was presented to Peoria attorney Roger Clayton, of Heyl, Royster, Voelker & Allen, and demonstrates a dilemma in dealing with adult patients who, if only temporarily, cannot make judgments about their care.

In this case, when the attending physician asked a few questions about the patient, he found some revealing information. "The children were the only two heirs for a rather large estate, and that was the motivation," Clayton recalled. The physician, along with another doctor, documented several conversations in which they told the children their father would be walking within 48 hours. When the children continued to push their agenda, the physician refused. The result: "The children never did another thing, and the patient remained on the ventilator until he was ready."

Clayton advised physicians to get a second opinion and document the results. "If you're going to err, do so on the side of preserving life," he said.

A PATIENT MAY HAVE surrogate decision-makers in place, but that can complicate the treatment if they disagree with the recommended medical care. Consider another case: An elderly patient has gangrene in both feet. He is unconscious, and his relatives insist he would rather die than face amputa-



Claudia Kunin/Tony Stone Images

Just because patients make poor decisions doesn't necessarily mean they need surrogates.

tions. The relatives, who are his legal surrogates, refuse to consent to the procedure. You feel strongly that the patient will not survive without it. Do you amputate?

In this case, Clayton said, the physician notified the hospital administrator about the differences in opinion, and the patient was transferred to another institution. According to Illinois law, "a health care provider is not required to comply with a decision to forgo life-sustaining treatment where compliance would conflict with the personal views or beliefs or conscience of the provider." The physician must, however, immediately notify hospital administration and help transfer the patient to another provider or facility that is willing to comply with the surrogate's decision.

When does a patient need a surrogate decision-maker? It's not always clear-cut. Take the hypothetical situation of an 85-

ily upset and is confused and disoriented. She needs a life-sustaining blood transfusion but has no living will or power of attorney.

Such situations are common, said Robert Wohlgemuth, director of Guardianship Services Associates, a social service agency based in Oak Park. The Health Care Surrogate Act would be the guide here, he explained. "The act applies when the following conditions exist: [There is] no living will or power of attorney; the patient lacks decisional capacity; and the patient has a terminal, incurable or irreversible condition or is in a state of permanent unconsciousness." Decisions must be made in writing by the attending physician and confirmed by at least one other qualified physician who has examined the patient, Wohlgemuth said.

But just because patients make poor decisions doesn't necessarily mean they need surrogates. For example, if you believe a patient with a history of drug and alcohol abuse should be discharged from the hospital and sent to an extended care facility, she may be legally able to decide to go home

instead. "My recommendation would be to respect the patient's wishes," Wohlgemuth said.

How do you get consent from a surrogate in an emergency? If you're faced with a Down's syndrome adult who needs emergency, but not life-sustaining, surgery, do you jeopardize the care while waiting for the proper paperwork?

Under Illinois' Good Samaritan statute, an attending physician who administered emergency care in certain situations would be protected from civil liability. If delaying treatment in a medical emergency would endanger the life or "adversely and substantially affect" the health of the patient, procedures can be performed without consent.

In these litigious times, Jim Christman, an attorney at Wildman, Harrold, Allen and Dixon in Chicago, provided some reassurance: "I can't think of one instance where a claim was made that a physician didn't obtain informed consent from an incapacitated patient or where a physician was sued for insisting on guardianship. Cases are usually based on negligence, et cetera — never just informed consent." ■

MALPRACTICE ROUNDUP

Jury finds MCO liable for failure to review patient records

A California jury awarded \$10.95 million to the family of a woman who died of metastatic cancer, finding that the woman could likely have been cured if the managed care organization had reviewed records received from an outside physician and continued proper treatment, according to the July issue of Medical Malpractice Law & Strategy.

In Rutledge vs. Friendly Hills Network, a nonplan Ob/Gyn diagnosed cervical dysplasia in the patient and monitored the condition through regular Pap smears. The patient subsequently enrolled in an MCO, at which point the Ob/Gyn transferred her records, and the records were stamped "received" by the MCO. But the MCO's Ob/Gyn treated the patient for various symptoms before eventually diagnosing metastatic cancer.

The patient's family claimed the MCO was negligent because it lacked a written protocol for routing and reviewing outside medical records and if the patient's condition had been diagnosed and treated in a more timely way, she would have had an 85 percent chance of cure.

The MCO conceded that it had no record review protocol but maintained that the patient should have followed up herself and that the disease was metastatic by the time she enrolled in the MCO.

Making sense of accreditation 'alphabet soup'

Physicians should know about the organizations that serve up accreditation.

BY WENDY ANDERSON
AND JANE ZENTMYER

As managed care organizations seek a competitive edge and verification that they represent "quality," accreditation has become more important than ever. Among the key accrediting players are the National Committee for Quality Assurance, based in Washington, D.C.; the Joint Commission on the Accreditation of Healthcare Organizations, based in Oakbrook Terrace; the AMA; and the American Accreditation Health Care Commission/URAC, based in Washington, D.C.

NCQA ACCREDITS MORE THAN HALF the HMOs in the United States. As is the case with most accrediting organizations, the committee requires MCOs seeking accreditation to begin by submitting documents that provide such information as a complete listing of physicians by specialty, provider sites, policies and protocols for review of medical records, and credentialing and recredentialing materials.

During site surveys, a three-member survey team, which includes a physician, takes a detailed look at documents like medical records and credentialing files, and interviews an array of the organization's representatives, including the CEO, the medical director and one practicing physician. The surveys take from one to four days, depending on the size of the organization and the extent of accreditation.

NCQA has recently gained attention for its proposed Physician Organization Certification program, which it hopes will lessen the burden for physician organizations affected by accreditation. The POC involves a single review of a physician organization by an NCQA survey team rather than the myriad reviews physician organizations now face from MCOs that seek NCQA accreditation. "This will make the MCO accreditation process that much more efficient, while still ensuring the same high standards of quality," said NCQA President Margaret O'Kane.

The streamlined process should help because NCQA is such a large player and because it requires annual audits of physician organizations. POC pilot programs are under way now, and the surveys should begin in October, according to a spokesperson.

The POC is designed primarily for physician organizations with 50-plus doctors, the spokesperson said. NCQA defines physician organizations as primary

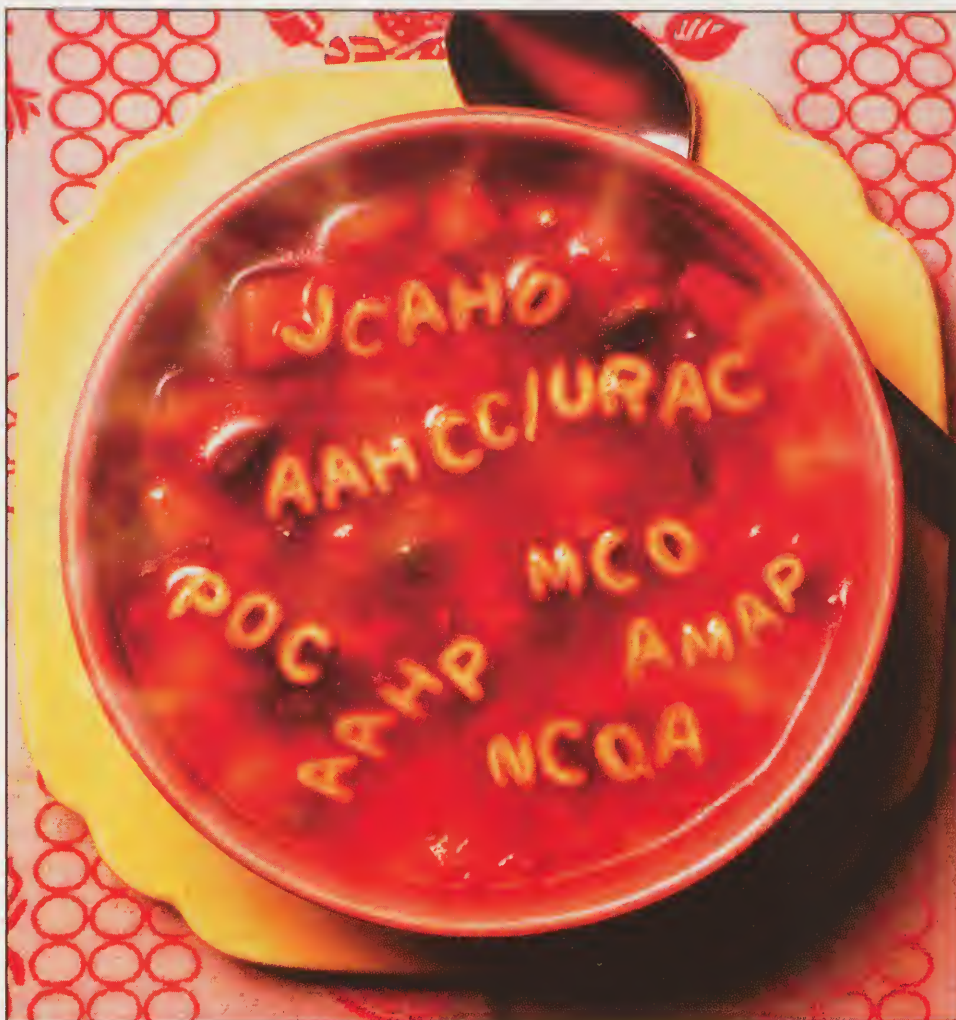
care or multispecialty groups and networks, PHOs, IPAs, integrated delivery systems and organizations that provide management services only.

The POC standards are, for the most part, a subset of NCQA's MCO accreditation standards. Although a few new program-specific standards were added, no significant changes were made to the existing MCO standards to apply them to physician organizations. The standards fall into the six categories of quality management and improvement, utilization management, credentialing and recredentialing, preventive health, members' rights and responsibilities, and medical records.

MCOs may delegate responsibility for all or only a few of the functions related to the six categories to their physician organization partners, and POs may seek certification for any or all of the six categories. The MCOs must continue to exercise some oversight of NCQA-certified physician organizations, but they won't be required to conduct annual on-site audits of the activities for which the POs have been certified.

The POC surveys will work this way: POs will be evaluated for each category for which they apply for certification. Surveys will be conducted on- and off-site by a two- or three-person team of physicians and managed care experts, and will last for one to three days, depending on the size of the PO. Initial certifica-

(Continued on page 8)



Rick Kroninger

Making sense

(Continued from page 7)

tion will last for one year, and after a second successful survey, certification may be extended for three years.

ADDED INTO THE MIX is JCAHO, which accredits about 18,000 organizations, including 11,000 hospitals and home health agencies. Almost 80 percent of the nation's hospitals, which account for 96 percent of all inpatient admissions, voluntarily work toward JCAHO accreditation. The joint commission also accredits home care organizations, behavioral care organizations and clinical laboratories. Since 1994, JCAHO has accredited a total of 19 HMOs, IPAs and PHOs through its health care network accreditation process.

In response to the demand for objective information about quality of care, JCAHO launched a process called Oryx in February to integrate outcomes data into its accreditation system. Previously, JCAHO judged an organization's ability to deliver outcomes based on its adherence to accepted standards.

The Oryx process will include performance measurement data as part of the JCAHO accreditation because business coalitions, employers and payers are demanding "objective evidence that they are buying good quality care for a fair price," according to JCAHO.

Oryx will be introduced slowly over the next few years, according to JCAHO. In 1997, accredited hospitals and long-term care organizations must select performance measurement systems with categories like clinical and health status from one of 60 JCAHO-approved vendors. Organizations must then select at least two clinical measures that encompass 20 percent of their patient population. Those measures may be condition-specific or procedure-specific or may address important functions of patient care such as medication use, infection control or patient assessment. Utilization measures are not clinical measures unless the rates are compared with a standard of quality. Data submission using these measurement systems must begin by March 1999.

Physician group practices may be included in JCAHO's accreditation through their association with MCOs or directly through the joint commission's ambulatory care program. Although JCAHO can accredit organizations like community health centers, physician offices, birthing centers and ophthalmology practices through the ambulatory care program, the joint commission has accredited only about 15 organizations to date.

"We think that will be an area of growth," said Julie McIntyre, a JCAHO spokesperson. "As physician groups become competitive, the accreditation may be a way for these groups to distinguish themselves in a competitive marketplace. Managed care may drive [accreditation] in that area."

Although the specific standards may vary, the accreditation process is essentially the same for each organization, said Julia Roberts, JCAHO's media relations specialist. To become accredited, an organization must undergo an on-site survey by a JCAHO team every three years.

The survey takes about three days, depending on the organization's size, Roberts said. The survey team interviews staff, reviews documents and observes

Translating the players' language

Accrediting organizations use terms differently, but the following are some of the basics:

Accreditation – a determination that a health care organization or network complies with the standards of the accrediting organization. Through the process, quality is assessed by ensuring that the network or organization has systems to deliver a certain level of care and service.

Accreditation appeal – a process through which an entity denied accreditation exercises its right to a hearing about the denial and potential reconsideration.

Accreditation duration – the period for which the accreditation is valid, usually from one to three years. After that point, reaccreditation is necessary.

Audit – a random inspection of medical records to verify the documentation of patient allergies, immunizations, referrals and so on.

Certification – a measurement of an entity's ability to comply with accreditation standards. It generally is not an overall endorsement of quality.

Credentialing – the process of verifying and documenting a physician's credentials, training and experience by checking with a primary source such as a medical school or a licensure board.

Credentials-verification organization – an entity that is paid to collect and verify physician credentials for another entity, such as a managed care organization.

Environment of care – a site, such as a physician's office, where care is actually administered to patients.

Environment of care survey – a visit to the physician's office by an accrediting team, usually to review medical and/or office record-keeping and procedures, assess hygiene and safety, interview staff, tour the facilities and so on.

Survey – an evaluation of an organization to assess its level of compliance with specified standards. A site survey refers specifically to a visit to some branch of an organization or network, such as a clinic, a physician's office or an environment of care.

– Wendy Anderson

the implementation of the organization's procedures. For a hospital survey, the team might follow patients through their hospital stays to see how the hospital's systems and processes work, Roberts said. "A hospital will have a system in place to do something, and [the team] wants to make sure that it works, that it's carried out and that it does what it says it's going to do."

THE AMA IS THE MOST recent entrant into the accrediting mix, but its program, which is currently in an embryonic stage, is specifically for physicians. "To our knowledge, accreditation has never applied to a group of individual physicians," said Lynn Thomas, AMA director of the division of accreditation policy.

AMA officials said they hope to have AMAP up and running in six or seven states by the end of 1997. One of the program's goals is to create a comprehensive, national database of physician information. Another is to reduce the fragmentation and duplication that accrediting processes often impose on physicians, especially when doctors are associated with more than one MCO and hospital, each of which uses different accrediting agencies, Thomas said. In those cases, physicians and their staffs may be forced to answer the same questions several times or respond to what seem to be conflicting criteria.

AMAP would incorporate other standards besides credentials and personal qualifications, Thomas said. These would include following the AMA's Principles of Medical Ethics, completing CME and participating in clinical and managerial self-assessment programs, organizations that require peer review "to discourage professional isolation," and, with some exceptions, on-site office surveys, Thomas explained. Physicians would have to pass a designated percentage of the standards and could gain extra points for exceeding them.

The hope is that a physician's AMAP accreditation would eventually be recognized by NCQA, JCAHO and perhaps

other accrediting agencies, Thomas said.

AMAP accreditation would cost \$50 for AMA members, and about \$125 for nonmembers. The program would largely be funded through the sale of information to MCOs and hospitals, Thomas said.

AAHCC/URAC HAS IMPLEMENTED new standards targeted at networks that are interested in being accredited specifically for their credentialing activities. The standards are based on a network's credentialing oversight processes, credentialing applications, requirements for primary and secondary verification of credentialing information, and oversight of creden-

tialing activities.

"We try to be nurturing and educational," said Lesley Malus, credentialing accreditation reviewer for AAHCC/URAC, which as of late July had accredited 21 PPOs, more than any other private accreditation entity, according to the commission.

Standards are developed by AAHCC's broad-based membership, which includes the AMA, the American Hospital Association, medical specialty societies and other groups, according to Guy D'Andrea, the commission's director of policy. "AAHCC prides itself on having medical leadership on its governing board. Our goal is to reflect the standards accepted and protected within the industry, with appropriate consumer and provider protections."

Physicians in AAHCC-accredited networks have other qualified physicians within the network with whom to confer, he said. Credentialing occurs in managed care settings using AAHCC standards that ensure that providers are qualified to give treatment, he explained. The standards also offer protections for physicians, D'Andrea said. "If incorrect information is obtained through the process, a whole process is in place to address that."

AAHCC also makes sure that physicians have input into credentialing through membership on MCO credentialing committees. On-site reviews of MCOs include evaluations of documents, a facilities tour, staff interviews and random audits of medical records. Interviews are conducted with the medical director and physician members of the MCO's credentialing committee. The survey team includes at least one physician.

A distinguishing feature of the AAHCC program is its focus on patient care sites and on the ways that systemwide mechanisms affect patients, according to a review by the Washington, D.C.-based American Association of Health Plans. ■

Edgar signs ISMS-supported bills

ACTION: Laws change reporting of lead poisoning test results, allow patients to appoint surrogates. BY JANE ZENTMYER

[SPRINGFIELD] There is good news for physicians who asked the ISMS House of Delegates to cause to be introduced or support certain bills during the spring legislative session. This summer, Gov. Jim Edgar signed several of those bills including the following:

LEAD POISONING TESTING NOTIFICATION S.B. 247, signed on July 23, amends the Illinois Lead Poisoning Prevention Act to require the reporting of only positive lead poisoning tests within 48 hours to the Illinois Department of Public Health. Negative results can be reported no later than 30 days after the end of the month in which they were received. The state previously required all results to be reported within 48 hours. Rockford Republicans Sen. Dave Syverson and Rep. Dave Winters sponsored the bill.

This new law's roots can be traced to a 1996 ISMS House of Delegates resolution. The reporting of all test results, particularly negative tests, within 48 hours significantly strains the resources available to process the information, the

resolution stated. "It would seem more cost-effective to report all positive-elevated levels within the 48 hours."

RIGHT OF CONSCIENCE, SURROGACY

The Health Care Right of Conscience Act and the Health Care Surrogate Act were amended when the governor signed one bill, H.B. 725, on July 29. The Health Care Right of Conscience Act now defines health care payers and exempts them from civil or criminal liability for refusing or arranging to pay for health care services that violate their conscience. The surrogacy act now recognizes patients' rights to surrogates, usually family members, who can make medical treatment decisions when patients are incapacitated.

"This bill addresses important issues fundamental to the delivery of health care in an appropriate manner for patients, health care providers [and payers]," said M. LeRoy Sprang, MD, chairman of the ISMS Board of Trustees, in a letter to the governor. Rep. Daniel Burke (D-Chicago) and Sen. Thomas Walsh (R-Westchester) sponsored the bill. ■

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Congress approves

(Continued from page 1)

The budget reconciliation measure also affects other physician reimbursements. Payment rates for durable medical equipment, for example, will be frozen from 1998 through 2002. And in 2003, DME reimbursements will be limited to the percentage increase in the consumer price index for all urban physicians, according to the ISMS analysis. Also, the cap on clinical diagnostic laboratory tests will be lowered to 74 percent of the national median of such services after Dec. 31, and reimbursement for those services will be

frozen from 1998 to 2002.

The Medicare reforms will expand reimbursements to include health services provided by nurse practitioners and clinical nurse specialists if certain conditions are met, according to the ISMS analysis. Nurses must work in collaboration with physicians and must be legally authorized to perform the service in the state where it is provided. Physician assistants, too, will see their reimbursement expanded but only in cases in which physicians would otherwise have provided the services. Both provisions will apply in rural and urban areas.

"Another positive step is the inclusion

in the agreement of medical savings accounts," Dr. Wootton said. "Some 390,000 Medicare beneficiaries will be able to use MSAs, which will put them in control of their primary health care needs. The AMA long has held that patient responsibility will result in optimal and cost-effective use of medical services." The MSA option is included in the newly created Medicare+Choice program, which was established to provide managed care coverage to Medicare beneficiaries, according to the ISMS analysis.

Watch upcoming issues of Illinois Medicine for more coverage of the 1998 federal budget reconciliation act. ■

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your phone

Department

(Continued from page 1)

Des Plaines, 9.51; and Prudential Health Care Plan, Chicago, 8.57.

In addition to HAMP, the following HMOs with complaints had the lowest ratings: Rockford Health Plans, Rockford, 1.23; Heritage National Healthplan, Moline, 1.26; NYLCare Health Plans of the Midwest, Oak Brook, 1.31; Principal Health Care of Illinois, Rockville, Md., 1.86; Aetna Health Plans of Illinois, Hartford, Conn., 2.44.

Patients issued about 90 percent of the complaints IDOI received, and health care providers filed the remainder, Grant said. About 92 percent of the complaints were related to claims processing, according to the agency. Underwriting problems accounted for another 5 percent of the complaints, and difficulties in policyholder services, marketing and sales led to the remaining 3 percent.

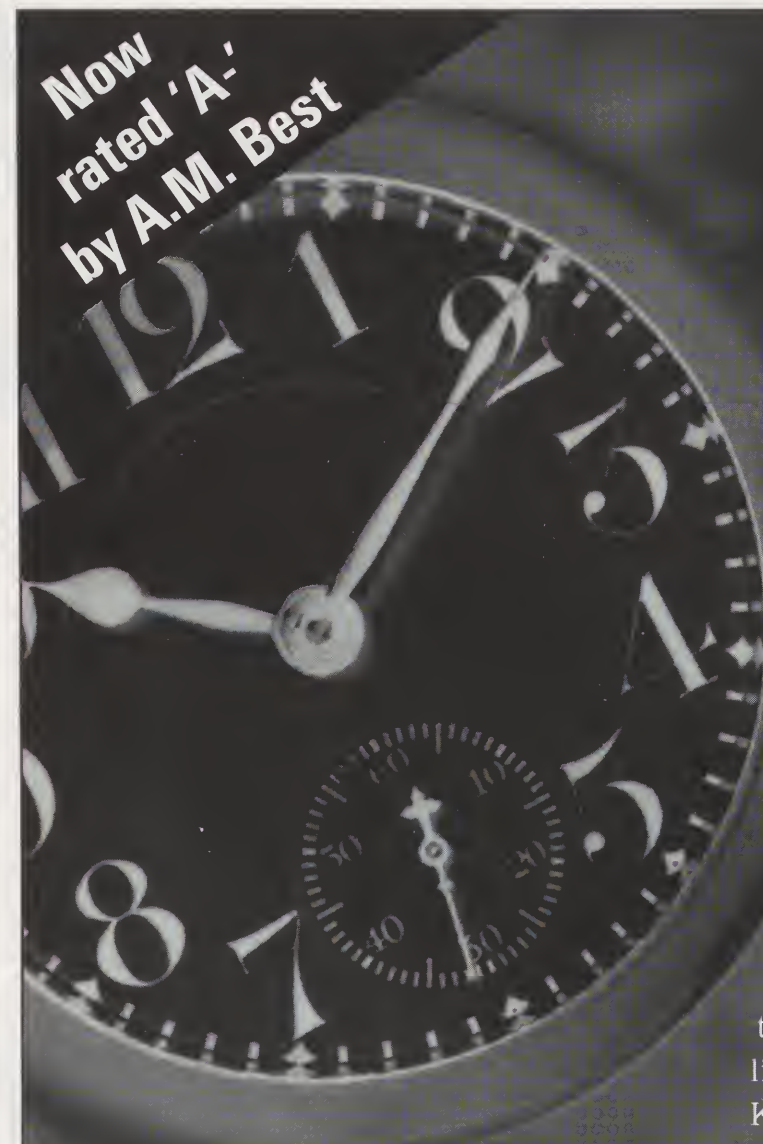
Many complaints dealt with the denial of payments for services and referrals, according to IDOI. The state also heard that some HMO directories had inaccurately listed the names of physicians accepting new patients, Grant said.

When a complaint is filed, the person filing receives a card stating that the correspondence has been received, providing the name of the person handling the complaint and verifying that the HMO has been notified.

Grant described investigations of complaints based on claims denials: "The HMO has a specific period of time in which they must provide us with documentation. Once we receive that documentation, we compare their reason for denying the claim with contract language, statutes and regulations. Based upon that review, we can then recommend whether there is a bona fide reason for denying the claim."

The department has recommended reversal of HMOs' actions in about 73 percent of the complaints, and the HMOs are bound by law to follow the statute or regulation, Grant said. If the HMOs challenge the recommendations, an IDOI hearing can be held to debate the interpretation, or it can be forwarded to the Illinois attorney general. Grant said he doesn't recall that either action has ever been needed.

To initiate a complaint, a patient or provider can write to IDOI, 320 W. Washington St., Springfield, Ill. 62767. E-mail can be sent to the agency through its Web site, www.state.il/ins. The complaint ratings for all the HMOs studied, as well as other insurance products such as automobile insurance, are available on the IDOI Web site. ■



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The question is,
Who should
make law?

PAGE 8

Illinois Medicine

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When
physicians and
patients part
ways

PAGE 7

Physicians testify about problems with access, emergency care

HEARING: Illinois Senate panel holds the third hearing out of five scheduled.

BY JANE ZENTMYER

[OAK BROOK] Even opponents of comprehensive managed care reform have stories about managed care decisions that just don't make sense. A situation illustrating that point was described by Eileen Boedigheimer, Northern Illinois Gas' medical administrator, when she testified at a hearing conducted Aug. 20 by the Illinois Senate's Subcommittee on Managed Care.

A pregnant employee, three weeks from her due date, was away from her Wheaton home and visiting in Moline when she delivered her baby, Boedigheimer said. But the employee's HMO refused to pay the approximate \$4,000 bill because having a baby is not an

MANAGED CARE

emergency, and the employee was treated outside the plan's area. The employee appealed the decision, but the payment denial stood because the contract stated that a woman close to her due date shouldn't leave the service area. The outcome changed only when her employer intervened.

This story was just one of many told during the third hearing of the Subcommittee on Managed Care. The subcommittee, whose chairman is Sen. Thomas Walsh (R-Westchester), is holding hearings to learn about potential managed

care reforms before crafting its own comprehensive bill. A bill passed by the House this spring, the ISMS-supported H.B. 626, also awaits the subcommittee's action.

At the hearing, opponents of reform argued that managed care has fulfilled its purpose of controlling costs while providing quality care. The proposed reforms would gut managed care and would increase premiums, opponents said. If health care insurance becomes too expensive, employers may stop offering it as a benefit, leading to more uninsured people. "The anti-managed care legislation currently being considered will

(Continued on page 13)

Lawsuit settlement calls for consensual drug testing of medical staff

SUBSTANCE ABUSE: AHA says case may cause hospitals to re-examine medical staff bylaws.

BY JULIE JACOB

[LUBBOCK, TEXAS] A Texas hospital's settlement in early July of a malpractice lawsuit filed against a staff physician may cause some hospitals to take a second look at their policy of relying on medical staff members to monitor themselves for drug and alcohol problems.

In the suit, a woman died during childbirth after an anesthesiologist with a history of drug abuse accidentally punctured a vein in her heart. The woman's family sued, alleging that the physician was drug-impaired during the delivery. As part of the \$9.5 million settlement with the family, South Park Hospital and Medical Center in Lubbock, Texas, agreed to test medical staff members, with their consent, for drugs and alcohol.

The terms of the settlement

are precedent-setting, according to Richard Wade, senior vice president of communications for the American Hospital Association in Chicago. "The settlement raises a whole series of questions regarding the relationship between hospitals and medical staffs, including the issue of random drug and alcohol testing." He added that the terms of the settlement may spur hospital governance boards to "take a second look at their bylaws regarding the medical staff."

The AHA supports random drug testing for hospital employees, Wade said, but is neutral on the issue of drug testing for medical staff personnel, since they are usually not hospital employees.

ISMS' House of Delegates opposes no-cause drug testing of
(Continued on page 14)



Matt Ferguson

GOV. JIM EDGAR announces appointments to his newly formed Commission on the Status of Women at a news conference Aug. 15 in Chicago. He said the commission will help "eliminate remaining barriers to equity for women across Illinois."

ISMS president appointed to commission on women

PROBLEM-SOLVING: Group will look at economic, employment, health issues. BY JANE ZENTMYER

[CHICAGO] On Aug. 15, Gov. Jim Edgar's newly formed Commission on the Status of Women took a step toward addressing the economic and social inequities that Illinois women face. At a news conference in Chicago, the governor announced the appointment of 20 Illinois women, including ISMS President Jane Jackman, MD, to the commission.

Despite successes, thousands of women still contend with wage inequity, the lack of affordable child and elder care, a glass ceiling in the workplace and problems related to retirement and economic security, Edgar said. "This commission will help us be more effective in our efforts as a state and as a society to eliminate the remaining barriers to equity for women across Illinois."

Dr. Jackman said part of her role on the commission will be to lead its work group on women's health issues. "Health care for women in Illinois is a

huge area, and we're going to have to pick and choose the more important issues," she said. Dr. Jackman added that she would like to address access to care, particularly obstetrical care, for women who live in rural areas, domestic violence and illnesses like osteoporosis and heart disease. "My hope is that the report of the commission will be meaningful and will be widely disseminated so that we can get some changes to improve the health care status of women in Illinois," Dr. Jackman said.

The women's health issues work group is just one of many work groups the commission plans to establish, according to commission chairman Paula Wolff, president of Governors State University in University Park. "We intend to do a lot of outreach around the state."

After the General Assembly failed to pass a bill calling for a women's commission during the
(Continued on page 6)

INSIDE

Three Catholic
health care
systems to merge



PAGE 3

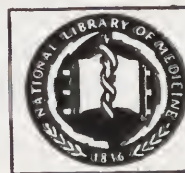
IDPA seeks
updated tax
information

PAGE 2

DEPARTMENTS

Malpractice
Roundup.....7

Classifieds11



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MEDICINE

IDPA seeks updated tax data

MEDICAID: Payments will be delayed after 60-day grace period.

BY JANE ZENTMYER

[CHICAGO] The Illinois Department of Public Aid sent about half the state's 40,000 Medicaid providers – including physicians, hospitals, medical equipment providers and transportation companies – a mailing in mid-August asking for updated tax information. Providers who received the mailing have a 60-day grace period to submit the information before payments will be delayed.

About 9,600 letters were sent to physician addresses. Because some physicians may have more than one account accepting Medicaid payments, the actual number of physicians may be less than 9,600.

IDPA is trying to ensure that the taxpayer identification numbers that are on

file for Medicaid providers match the numbers on file in the state comptroller's office. A computer check of the departments' records detected conflicting numbers for the 20,000 providers who received the mailing, according to IDPA spokesperson Dean Schott.

"The idea is to have accurate, up-to-date current information for the Medicaid program and [Internal Revenue Service] purposes," Schott said. The mailing includes a letter explaining the problem and an IRS form that should be used to file the updated taxpayer identification numbers.

"We're trying to work with the provider community to minimize any

disruption, and the 60-day period will give them leeway in which to respond," Schott said. "We still urge them to do it as quickly as possible. They only have to do it once, and once they're certified they will not have to worry about it again."

The state is asking for the correct information in response to new IRS requirements for reporting provider names, payee names and taxpayer identification numbers, Schott said. Physicians who didn't receive a mailing either have correct information on file or resolved any discrepancies before the letters were sent. Only physicians who received the mailing need to provide updated information.

In some isolated cases, payments to physicians and other providers may have been delayed if the tax information differed between departments, Schott said.

For more information, physicians may call IDPA's provider participation unit at (217) 782-0538 or (217) 524-7306. ■

Unicare to administer state's health benefit plan

[SPRINGFIELD] Unicare, a national operating subsidiary of WellPoint Health Networks Inc., assumed the administration of the state's self-insured, fee-for-service health benefit plan on July 1. More than 200,000 of the 380,000 state employees and retirees and their dependents receive health benefits from the Quality Care Health Plan, according to the Illinois Department of Central Management Services. The remaining 180,000 receive benefits through other health plans the state offers, such as HMOs.

"Illinois is an important market for us, and we believe the contract with the state is important to our strategy of gradually introducing a wider spectrum of quality health services, which we make available to individuals, families and seniors, and small, medium and large firms," said Unicare President D. Mark Weinberg. "Our goal is to create a new platform for health care plans around the country that focus specifically on consumer needs."

Unicare was the low bidder on the five-year, \$87 million contract to provide claims administration, customer service, management of the state's hospital provider network and account management for Quality Care, according to IDCMS spokesperson Kim Bateman. The contract does not change any benefits now offered to state employees.

Unicare also serves about 124,000 Illinois residents through its purchases of the Massachusetts Mutual Life Insurance and John Hancock Mutual Life Insurance Co. group life and health subsidiaries. To accommodate the increase in Illinois business, Unicare will add 400 employees to its Illinois base and will consolidate several Midwest sites into two Chicago area centers, according to the company.

Unicare's parent, the Woodland Hills, Calif.-based WellPoint Health Networks Inc., is one of the nation's largest publicly traded managed care companies. ■



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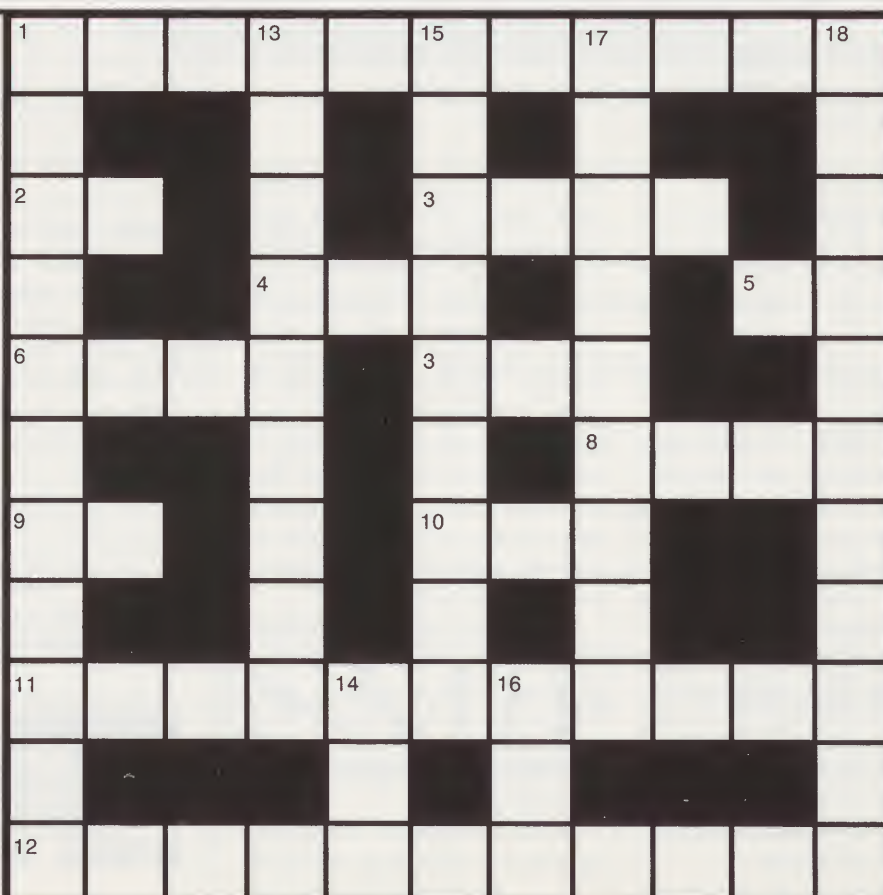
This crossword puzzle, like our PBT benefit plans, is designed especially for physicians!

Across

1. Infection with flukes or trematodes.
2. Symbol for rubidium.
3. The East Indian plant *Oldenlandia umbellata*.
4. The organ of hearing.
5. Symbol for erbium.
6. Abbreviation for the American Association for the Advancement of Science.
7. A combining form meaning egg or ovum.
8. Structural and functional unit of life.
9. Symbol for ytterbium.
10. Abbreviation for the American Association of Immunologists.
11. A febrile disease with cough and dyspnea; seen in persons who work with reclaimed wood.
12. A genus of blood flukes infecting man.

Down

1. A genus of itch mites.
13. The entrance of a canal.
14. Abbreviation for despectiated bovine serum.
15. Conjugation of two adult protozoan cells.
16. Fever of undetermined or unknown origin.
17. An agent that destroys acarids.
18. A bursa found in the aged.



Smoke signals

States with most smokers age 18 to 30

Percent

Maine	32
Ohio	31.2
Rhode Island	30.9
Indiana	30
Alaska	29.7
Pennsylvania	29.5
Delaware	29
North Carolina	28.8
Michigan	28.6
West Virginia	28.6
Kentucky	28.2
Median, all states	24.5

Source: U.S. Centers for Disease Control and Prevention, 1995

Three Catholic health care systems prepare for October merger

CONSOLIDATION: New organization will staff 1,400 physicians.

BY JANE ZENTMYER

[CHICAGO] Three Roman Catholic health care systems serving northern and central Illinois have finalized the details of their pending October merger. The systems are the Franciscan Sisters Health Care Corp. in Frankfort, Mercy Center for Health Care Services in Aurora and ServantCor in Kankakee. Gross revenues for the three entities in 1996 were \$1 billion.

"This isn't a shotgun marriage," said Stuart Fulks, vice president for planning and marketing at ServantCor. "Each one of these systems brings different strengths to bear."

The completion of the merger hinges on federal approval and the three organizations' working through some of the remaining legal details, officials said. The affiliation agreement must still be approved by ServantCor's sponsor, Servants of the Holy Heart of Mary, Holy Family Province. The agreement has already been approved by the other two organizations' sponsors - Franciscan Sisters of the Sacred Heart and Sisters of Mercy of the Americans, Regional Community of Chicago.

Officials said the merger will help strengthen the Catholic health care option in Illinois and will create an organization that can work with other Catholic and non-Catholic health care organizations. Chairman of the Mercy Center's board of directors Thomas Zarle said, "While the merger will produce some cost saving opportunities from increased economies of scale and the potential future consolidation of selected services, the purpose is much broader. That purpose is to provide a complete continuum of care to manage the health of the population we serve."

THE NEW ORGANIZATION will be composed of seven hospitals with 2,000 beds and 11 long-term care and residential facilities with 1,200 beds. Assets will include 38 off-site clinics, six home health agencies and six home medical equipment outlets. More than 10,500 employees and 1,400 physicians will work at the organization, which has not yet been named.

The seven hospitals are Covenant Medical Center in Urbana, Mercy Center for Health Care Services in Aurora, St. Joseph Hospital in Elgin, St. Joseph Medical Center in Joliet, St. Mary's Hospital in Kankakee, St. Therese Medical Center in Waukegan and United Samaritans Medical Center in Danville. In

1996, these hospitals admitted almost 68,000 patients, delivered more than 8,000 babies and performed more than 50,000 surgeries.

"We don't see any changes in the local communities with respect to how our physicians interact with our hospitals," said Gerald Pearson, CEO of Fran-

ciscan Sisters Health Care Corp. "The medical staff structures that are currently in place are going to stay in place. The physicians are going to continue working with their local hospitals and boards of directors locally."

Physicians in the merged system will benefit from working with peers who previously may have staffed competing hospitals. "For example, we had physicians in Waukegan who put on a seminar for physicians in other hospitals about managing c-sections and it was very well done and very well received by other physicians," Pearson said.

The areas served by the hospitals will

benefit from the Catholic health care philosophy of investing in the health of communities and helping them solve their own problems, officials said. "The problems of the community are our problems; the solutions to the community are our solutions," Pearson said.

The merger will also help prepare the three systems for the future. "All facilities in the state are probably looking to demonstrate that they're the highest-quality and lowest-cost facilities," Fulks said. "We recognized that we can learn from one another, not just in areas like managed care, but also in areas like quality improvement."

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EDITORIAL

Good news for kids' health

We heard some good public health news in August when President Clinton announced that beginning next year, pharmaceutical companies will have to test the safety of prescription drugs for children, determine proper dosages and label drugs appropriately.

Only 20 percent of all drugs currently marketed in the United States are labeled for use by children, according to the American Academy of Pediatrics. So, the directive will eliminate the guesswork that physicians have been forced to do. It will also broaden the range of drugs for children, since there's so little information about some drugs that doctors may have avoided prescribing them. It may be a challenge to get parents to allow their kids to participate in tests, but the ultimate benefit to all children, including their own, may help convince them.

The testing and labeling problem hasn't been limited to what many consider typical medications for kids – like antibiotics. Asthma, for example, is the leading cause of hospitalization of children in the United States and commonly affects kids under age 5. Yet only one asthma drug is labeled for use in children under 6, according to AAP.

Last year, about 600,000 children and adolescents were prescribed the antidepressants Prozac, Paxil or Zoloft, according to IMS America Ltd., a research organization. For adolescents between 13 and 18 years old, prescrip-

tions for Prozac alone increased 46 percent last year.

"Children are undergoing physiological changes and may be particularly vulnerable to the effects of drugs," said an official of the Food and Drug Administration. When you combine that vulnerability with the fact that drugs like antidepressants may be taken for years, the risk increases.

Drug companies have been reluctant to test children partly because of the cost, which was estimated at \$20 million per year in the Chicago Tribune.

In addition to cost, potential profits are sometimes a factor where children's health is concerned. The beverage industry's high-caffeine "energy drinks" have drawn criticism from some public health experts who say that caffeine is mood-altering and at least somewhat addictive. The drinks have even been banned by some schools. One product, called Guts, is due out this month. It was originally aimed at ages 12 to 24, but the target group was expanded to include 9-year-olds, and the manufacturer will use cartoon characters to market the product. The draw for manufacturers is that energy drinks are the fastest growing segment of the soft-drink business, and the product appeals to kids, according to the New York Times.

It's a shame when dollars take precedence over children's health, but as the new prescription drug directive shows, there's always potential for change.

PRESIDENT'S LETTER

Appreciating Gov. Edgar's legacy

Jane L. Jackman, MD



We have no choice other than to become political activists if we care about the quality of care our patients receive.

On Wednesday, Aug. 20, we finally had the answer to the latest \$20 million question in Springfield: Would Gov. Jim Edgar run for a third term, take a shot at the U.S. Senate or retire? Political observers had speculated for weeks, with the majority favoring his continuing his successful political career. The overwhelming reaction to his answer – retirement from politics – was shock tinged with some disappointment. He is universally seen as an honest, hard-working person who really cares about the people of Illinois.

The doctors of our state will especially miss his leadership. Even though we haven't agreed on every issue, we know he listens to us and appreciates our expertise in medical matters. We are grateful for his unflagging support of tort reform and his willingness to sign the bill that set a cap on noneconomic losses. With his support and encouragement, coupled with a medical majority in the House and Senate, we were able to complete 20 years of work on lawsuit reform. Even though the fate of the law is now in the hands of the Illinois Supreme Court, tort reform was and is a tremendous victory for our patients.

Of course, the governor helped us with many other issues – most recently by signing pro-patient bills that prevent drive-through deliveries and mastectomies and that give managed care patients direct access to their gynecologists. When he was secretary of state, he supported lowering the legal limit for blood alcohol concentration to .10 percent and stiffening the penalties for drunken drivers. This last year, he had the satisfaction of signing legislation that was a priority for Secretary of State George Ryan and that lowered the BAC to .08. We will have the opportunity to continue working with the governor for 16 more months, but we will certainly miss him when he steps down.

The elections of the new governor and state representatives and senators are much too important to be left to chance. Our legislators make laws that increasingly govern how we may practice medicine.

Every year hundreds of health care-related bills are considered by our legislators. We have no choice other than to become political activists if we care about the quality of care our patients receive. Ninety-eight percent of our Springfield lawmakers are elected with no formal knowledge of health care, but they make decisions that impact almost every aspect of our professional lives.

We can help elect legislators who understand our viewpoint by giving to the Illinois State Medical Society Political Action Committee. It's discouraging that only two of every five ISMS members give to IMPAC. If all 18,000 members became IMPAC "supersustainers," just think how effective we would be! For just 41 cents a day (less than the cost of a cup of bad hospital coffee), we can all help elect men and women who will deal responsibly with medical issues in our Legislature.

The other critical way we can influence the political process is to assist pro-medicine candidates in their election campaigns. In fact, our current governor started his political career as the state representative from Charleston, with his campaign treasurer being a local doctor, Mack Hollowell, MD, and assistance from George Mitchell, MD, of Marshall, and Pam Taylor, from the ISMS Alliance.

Because of the power shift in Springfield and the challenges to tort reform, this next year of political action will be critical. Rest assured, medicine's candidates will be targeted by plaintiff lawyers who are eager to nullify our successes. We need not only to maintain our hard-won gains, but also to advance pro-medicine legislation. Join IMPAC, work on political campaigns, host a fund-raiser, write letters of support to your friends, put up a yard sign, work a precinct or invite a candidate to a meeting of your hospital medical staff or county medical society.

Legislators are determining our future. Isn't it only fair that we have a strong voice in choosing who those people are?

GUEST EDITORIAL

Some facts about AMAP

By William Jessee, MD

The AMA is developing its American Medical Accreditation Program to accredit physicians based on standards related to their education, licensure, ethics and practice operations. The program will replace duplicative physician assessments and will be phased in state by state. The following are some of the questions that ISMS members may have and answers from the AMA.

Where will AMAP get its information about physicians?

AMAP will initially compile information from two sources: the physician's application and the results of a review of the physician's practice. The application will be similar to current applications for participation in health plans or membership in hospital medical staffs. All of this data will be in a single electronic file that will be made available to hospitals and health plans in which the physician wishes to participate.

AMAP will eventually include data on clinical performance and patient care results. At that point, other sources will be added. The specific sources will be the subject of pilot testing over the next two or three years.

Will AMAP credential physicians?

AMAP itself will not credential physicians. The credentialing function will continue to be performed by each hospital medical staff and each health plan. AMAP, however, will be a single source of information about physician credentials and qualifications that can be used by any hospital or health plan that participates.

What exactly will participating physicians need to do?

The physician who chooses to participate in AMAP will complete one application for accreditation every two years and undergo one review of his or her office. This information can then be provided to every hospital and every health plan that agrees to use AMAP information.

How is AMAP different from physician profiling, in which the public can access information like malpractice records?

Specific profile data about individual physicians will not be made available to the public. The AMAP physician portfolio of information – including information on qualifications, the results of the office review and ultimately clinical performance and patient care results – will be provided only to the physicians themselves and to participating hospitals and health plans.

What control will physicians have over the collection and interpretation of information about their practices?

Physicians will be provided with uniform feedback on their own clinical performance and patient care results and can work with their county and state medical societies and specialty societies to ensure that such information is interpreted accurately.

How will one set of practice standards reflect the practice of medicine when specialties vary significantly?

AMAP accreditation will reflect standards that are not specialty-specific but that describe the characteristics of a quality physician, regardless of specialty. Over time, AMAP will tailor its office review criteria to better reflect differences in the practice of individual specialties. The standards used for evaluating clinical performance and patient care results will be based on the problem for which the patient is being treated. For instance, the standards for managing congestive heart failure would be the same whether that patient was managed by an internist, a cardiologist, a geriatrician or a family physician.

How does AMAP compare with the National Practitioner Data Bank?

The National Practitioner Data Bank is simply a repository of information on disciplinary actions and malpractice claims. AMAP is a standard-setting program that evaluates physician qualifications and performance against national standards, renders an accreditation decision and provides a comprehensive report to physicians so they can continuously improve the quality of their patients' care and their office operations. AMAP will give a balanced picture of a physician's qualifications and performance, not simply list negative information as is the case with the National Practitioner Data Bank.

What input have physicians had in the development of AMAP?

AMAP has been developed almost exclusively by and for physicians. Although the AMAP Governing Board includes representation from employers, consumers, managed care organizations, hospitals and others, it consists mostly of physicians. The standards, survey procedures and operating policies have been developed by four advisory committees composed almost exclusively of physicians from state and country medical societies, national medical specialty groups and the American Board of Medical Specialties.

What incentives do MCOs have to accept AMAP?

MCOs will use AMAP because it is much cheaper for them to purchase information from a single source than it is to collect it themselves. AMAP will meet all requirements placed on managed care plans by the National Committee for Quality Assurance and the Joint Commission for the Accreditation of Healthcare Organizations.

When will AMAP be available to Illinois physicians?

We anticipate that AMAP will be available in all 50 states by the end of 1999. We expect the implementation process to occur in Illinois in the near future.

Dr. Jessee is the AMA's vice president for managed care and quality.



"I'll take the bone scan, but I refuse the cat scan."

GUEST EDITORIAL

On the run

By Richard Trefzger, MD

Several years ago, after I had been running for about three months, I had what I now call a "Forrest Gump" experience. I felt so good running one morning that I began wondering why I couldn't simply run forever, just as Forrest wanted to do. Why should I stop something that made me feel so good? Of course, I knew that I'd eventually have to eat and sleep, but I was surprised that I had to think about the answer. My running friends said that incident probably signaled that I was ready to run a marathon. The next thing I knew, I had purchased a book about marathon running and begun planning a strategy to qualify for the upcoming Boston Marathon.

Injuries forced me out of my first Boston runs, but I qualified in April and finished about 6,000th among more than 11,000 runners.

I run because I enjoy the way it feels, the competition of marathons and the camaraderie with other runners. I also enjoy the self-confidence that running – or any exercise – instills.

My history with running goes back a few years. As captain of my cross-country team, I ran a two-mile race, which at the time I thought was longer than my body was equipped to run. After high school, I realized that I had completely burned out on the sport, and I knew it was time to do other things. A little later, I yearned to run again, but I couldn't find a way to fit it into my new pursuits. I tried at different times to start again, but those efforts lasted for only a few days or weeks.

Four years ago, I went to Russia on a medical mission. Because of the time difference, I didn't sleep well and awoke every day at about 4 a.m. One morning, I stopped trying to force sleep and decided to go for a short run. It felt good, but I quickly realized that I was in poor shape. For reasons I cannot explain, I found myself rising early when I returned home – a big change for someone who has always had a hard time

awakening in the morning. I used that time to ease back into running, and I discovered another surprise: Virtually no one called between 5:30 and 6:30 a.m.

Because I'm a general surgeon, I am frequently on call for trauma cases at the emergency department, so I've always been afraid that if I went running, I'd be unable to respond to calls quickly enough. I resolved that concern by carrying a small pager and a lightweight cellular phone that fit into a fanny pack. Still, I seldom get calls at that hour.

I truly value the time I spend running. Although some runners enjoy training together and talking with someone to help pass the time, my schedule doesn't lend itself to that. There is also the advantage of having time to yourself to meditate or think or simply enjoy the beauty of the outdoors. It is fantastic to see a sunrise or the lakes, farms, fields and houses along my path.

Physicians who want to take up running might start by walking and gradually increasing the amount of running. You can get tips about training in books such as "Book on Running" and "Marathon" written by former Olympic runner Jeff Galloway. For runners over 40, "Masters' Running" by Bill Rogers is a good choice. In fact, had I read Rogers' book years ago, I could have avoided some injuries by recognizing my body's limits.

Another resource is the American Medical Athletic Association, which provides valuable information and help in qualifying for major marathons. You can phone the group at (818) 363-8511.

To be a successful, lifelong runner, you simply have to enjoy running. I run because I enjoy it, and I'm a disciplined runner because I get even more enjoyment from running races like the Boston Marathon. I enjoy the self-confidence running brings and the goals the sport helps me achieve.

Dr. Trefzger is a general surgeon in Bloomington.

Loyola unveils new student facility

[MAYWOOD] The 520 students who began classes at or returned to the Loyola University Chicago Stritch School of Medicine on Aug. 4 were the first to do so at the school's new \$43.8 million, four-story building.

"Completion of this new medical school is a major milestone that signals Loyola's continued growth as a leader in medical education and health care," said Anthony Barbato, MD, president and CEO of Loyola University Medical Center and the Loyola University Health Sys-

tem. "The facility will be a model for the education of physicians."

The 195,000-square-foot structure replaces the school's previous facility at the Loyola University Medical Center, which opened in 1968. The development of the new building began in 1991 with a review of the school's medical education program. "The development of the new medical school has indeed paralleled the revamping of our medical curriculum," said Ralph Leischner, MD, senior asso-

ciate dean of the medical school.

The building's design will help facilitate the integration of basic and clinical sciences; the shift from such traditional teaching methods as large student lectures to active, small-group discussions and self-teaching; the development of skills in interviewing and examining patients; and the promotion of student interaction.

The new building includes small-group labs with computer hook-ups to teaching software and exam rooms equipped with video monitoring to allow faculty members to monitor students' interactions with patients. ■

ISMS president

(Continued from page 1)

spring session, Edgar accomplished that goal by issuing an executive order on June 23. The state had eliminated a similar panel in the 1980s, and nothing was established to take its place, Edgar said, adding that most states already have such a commission in place.

Edgar said the experiences of his mother, his wife and his daughter led to his decision to create the commission. His mother experienced pay inequities when she re-entered the workforce after the death of his father in the 1950s. His wife, Brenda, recently established her own campaign, called Friend to Friend, to examine women's health issues. She will serve as an ex-officio member of the newly created commission.

In addition to examining pay equity, mentoring and apprenticeship, day care, elder care, retirement and economic security, the panel will recommend improvements to current state laws and programs, Edgar said. He added that the commission can suggest changes that don't require legislative action. "Also, the commission will make recommendations in the ways public and private partnerships can boost awareness and [lead to] solutions to the problems facing women," Edgar said. An interim report on the commission's findings is due to the governor and General Assembly by Feb. 1, 1998, with a final report due Dec. 1, 1998.

Edgar pointed out that Illinois women have recently made great strides toward equality. For example, Illinois women own almost 336,000 businesses, which ranks Illinois fifth among all states. Those Illinois businesses employed almost 1 million workers in 1996, he said. In Chicago, women make up one-fourth of all small business owners.

But those successes are just a beginning, and the commission faces the challenge of convincing others to keep looking at discrimination against women, Wolff said. "It's true that women are doing better than they have in the past, but it's also true that there are still enormous obstacles that women face — problems that each of us confronts in our daily lives."

LaSalle National Bank, the commission's first corporate sponsor, will contribute toward the commission's travel expenses, printing costs and other needs. ■



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REPORT for Illinois Physicians

Biopsy Techniques for Non-Palpable Breast Lesions

The increasing availability and utilization of mammography has lead to the identification of a subset of women who are asymptomatic and who have no detectable lesions on manual examination but who nevertheless have a suspicious lesion identified by the mammographic study.

Biopsy to obtain tissue for pathological diagnosis is the usual next step in the evaluation process. Three general biopsy techniques are available.

1. Surgical Biopsy (SB) is considered the gold standard to which other techniques are compared despite the fact that a lesion may occasionally be missed. This technique requires pre-biopsy placement of a hook wire into the lesion by radiological guidance and provides the entire lesion for examination. This procedure may lead to cosmetic deformity in a percentage of women and may cause sufficient scarring to make future mammograms difficult to interpret.
2. Needle Core Biopsy (NCB) utilizes a large bore (usually a 14-gauge) needle with stereotactic or ultrasound guidance to obtain 5 or more samples of tissue, each sample being 1 to 2 cm. in length. Enough tissue is obtained to allow tissue diagnosis and tissue pattern identification.
3. Fine Needle Aspiration (FNA) utilizes a small (usually a 23-gauge) needle with stereotactic or ultrasound guidance to obtain tissue. This method obtains only small clumps of cells and does not allow identification of tissue patterns that are essential in determining the invasive nature of any identified malignancy. Additional techniques are needed when malignant cells are identified but the invasive pattern is unknown, or when no malignant cells are obtained despite a "highly suspicious" mammogram.

Surgical Biopsy (SB) or NCB are considered medically necessary for evaluating non-palpable breast lesions. Fine needle aspiration is considered investigative for evaluating non-palpable breast lesions.



Amy Rothblatt

ISMS' MOST RECENT Employee Recognition Award winner is ISMIE underwriting supervisor Keith Evans. He was recognized for leadership that encourages creative solutions to meet the needs of physician policyholders.

ISMIE Update

Coming soon:
Getting
consent to
treat children
in foster care

When physicians and patients part ways

Avoid an abandonment situation by communicating with patients and documenting that communication. BY CHRIS SMITH

Consider this possible situation: A family physician consistently warns a cardiac patient about the need to quit smoking, but the patient consistently refuses to comply. After several years, the patient announces that he's tired of the physician's nagging and that he won't return for further treatment. Unless the physician documents that the patient decided to leave the practice, the door could be opened to a claim of abandonment.

Physicians need to understand the issues surrounding termination of a physician-patient relationship and ways to provide for continuity of patient care, according to Albino Bismonite, MD, a member of the Risk Management Subcommittee on Pediatrics and a Gurnee pediatrician. "It's important to document everything properly," he said.

When abandonment suits occur, they usually turn on documentation, according to Peter Monahan, a senior partner in the Chicago law firm Alholm & Monahan. "Specifically, doctors must implement a prescribed system of protocols to limit their liability."

For starters, physicians must determine the status of their relationships with individual patients, because patients cannot be abandoned unless the physician-patient relationship has been established. Once the relationship is established, it lasts as long as the need for care lasts, Monahan said. "Specifically, in the case of illness, the physician must provide treatment until the patient recovers or dies. In the case of a patient who needs a series of treatments, the series must be completed [before the relationship ends]. In cases when a physician or specialist is called for a consultation, the consultation must be completed."

When patients decide not to pursue prescribed treatment,



Gary S. and Vivian Chapman/The Image Bank

physicians should document that fact with a registered letter confirming the decision, according to Jim Neville, senior partner with the law firm Neville, Richards, DeFranco & Wuller in Belleville. "The letter should notify the patient that continued care is necessary and should give instructions on how to find another physician, usually a neutral source such as a county or state medical society referral service."

But if the patient has a continuing medical problem, the physician is responsible for care until a substitute is found, and the doctor must either find a substitute or provide sufficient written notification to the patient to allow him or her to find a substitute, according to ISMIE risk management material.

"The physician should inform the patient that he or she will provide emergency care for the patient until a new physician is located – usually for a stipulated period," Neville said. "If possible, obtain a signed statement of discharge from the patient, but this is eas-

ier said than done, because angry patients will not provide one."

Many cases of abandonment occur accidentally when patients don't know what's going on with their care, Neville said. "For example, there are numerous doctors involved in one case, and one doctor thinks another doctor is handling it but doesn't follow through, so the patient mistakenly believes his or her care has come to an end because no one is communicating with him or her."

Another abandonment issue involves contacting patients about results of lab tests or biopsies. "Sometimes a physician gets the results of a lab test and tries to contact the patient but gets no response even after numerous phone calls and letters," explained Peter Donahue, a senior partner in the Chicago law firm of Donahue, Brown, Mathewson & Smyth. Each attempt must be documented, and copies of any written communication must be kept in the patient's file. "When lab or test results indicate that the patient

MALPRACTICE ROUNDUP

Patient, husband awarded damages for genital injury caused by traction

A Brooklyn, N.Y., jury awarded \$3.7 million to a patient whose genitalia was injured during postorthopedic surgical care. Her husband was awarded \$1.3 million for loss of consortium, according to the June issue of Medical Malpractice Law & Strategy.

In *Koplowitz vs. Fellicia*, a New York superior court jury found a physician and a hospital negligent in the application of traction after the patient's surgery. During surgery to repair a fractured pelvis and femur, she was placed in traction with a post between her legs to provide counter-traction. She complained of pain and swelling in the vaginal area, and a month later, she was diagnosed with dermal and neural necrosis. The necrosis rendered her sexually dysfunctional. The patient claimed she was injured by the improperly positioned post.

Jury finds poorly performed spinal tap caused brain damage in infant

A Queens, N.Y., jury awarded \$27.5 million to the family of an infant who sustained severe brain damage after being improperly positioned during a spinal tap, according to the July 21 edition of the National Law Journal.

In *Cabrera vs. New York City Health and Hospitals Corp.*, an 8-month-old child presented with an ear infection and fever at the hospital emergency department. To rule out spinal meningitis, the infant was given a spinal tap, during which a nurse bent the child's neck, cutting off oxygen to his brain and causing brain damage.

The infant's mother charged that hospital personnel positioned the child incorrectly and failed to monitor him and that the hospital should have had an experienced doctor present during the procedure.

The hospital denied any negligence, maintaining that the boy experienced sudden cardiac arrest unrelated to the spinal tap.

The jury found for the plaintiff, but the \$27.5 million award will be reduced to \$15 million in accordance with New York law. The defense said it plans to file motions to set aside and reduce the verdict.

needs additional treatment, the physician really must go beyond the letters and calls. Start with a certified letter and keep receipts as proof that the letters have been sent. Attempts also should be made to notify next of kin. If the patient still cannot be found, physicians may want to notify their lawyers to let them know what is going on or to come up with another course of action."

Under managed care, patients switch physicians more often,

which places an extra burden on physicians to ensure continuity of care, according to ISMIE risk management background. Physicians should evaluate the procedure used by the managed care organization to determine how care is transferred and how the patient should be notified. A letter from the MCO to the patient may be enough. But if a patient is in the midst of treatment, physicians may need their own notification protocol. ■

The que Who should

Tort reform supporters explain why th

BY JOHN E. MUENCH



Robert Saunders/SIS

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Two years after its enactment, the landmark Illinois tort reform legislation has made its way onto the docket of the Illinois Supreme Court. On March 19, the court heard argument in *Kunkel vs. Walton*, a case involving the constitutionality of a single provision of the tort reform act regarding the scope of the physician-patient privilege. Then on May 21, the court heard argument in *Best vs. Taylor Machine Works et al.*, a consolidated appeal in which the constitutionality of the entire legislation is at issue.

The central question in the tort reform cases is the scope of the General Assembly's power to modify the state's civil justice system. Circuit courts around the state have very narrowly construed this power in striking down various aspects of the legislation, most frequently on separation of powers grounds. These courts have concluded that the General Assembly encroached upon judicial functions by, among other things, capping noneconomic damages and abolishing joint and several liability. They also have relied

upon other constitutional doctrines – such as equal protection, due process and special legislation – as additional (or alternative) grounds for concluding that the General Assembly had overstepped the bounds of its constitutional policy-making authority. As demonstrated below, however, none of these purported rationales support the invalidation of any, let alone all, of the tort reform amendments. Indeed, it is the courts that have usurped the General Assembly's legitimate policy-making power and not the other way around.

Pursuant to Article IV, Section 1 of the Illinois Constitution, "all legislative power is vested in the General Assembly subject to the restrictions contained in the constitution," according to *People ex rel. Tuohy vs. Chicago Transit Authority*. The core components of the legislative power are "the power to enact laws," according to *People vs. Bainter*, and the duty to articulate "the primary expression of Illinois public and social policy," according to *Charles vs. Seigfried*. Indeed, on several occasions the Supreme Court of Illinois has expressly stated that "declaring public policy is the domain of the Legislature," according to *People vs. Felella*. As former Chief Justice Michael Bilandic recently explained in the *Charles* case, public policy first and foremost "should emanate from the Legislature" because, among other reasons, "it is the only entity with the power to weigh and properly balance the many competing soci-

Question is, make law?

General Assembly should make policy.

ROBERT M. DOW JR.

Illinois courts
historically
have made
every effort to
avoid invalidating
legislative
enactments.

etal, economic and policy considerations involved."

The Chicago Transit Authority case recognized that "the modern concept of public purpose is elastic and capable of expansion to meet changing conditions," and Illinois courts have allowed considerable leeway to the

General Assembly in discharging its policy-making duties. As a threshold matter, "legislation is presumed to be valid, and the party challenging the constitutionality of a statute has the burden of establishing its invalidity," according to *DeLuna vs. St. Elizabeth's Hospital*. Moreover, "it is a court's duty to construe a statute so as to affirm the statute's constitutionality and validity, if reasonably possible," said *People vs. Shephard*. The same case stated that "if the statute's construction is doubtful, a

court will resolve the doubt in favor of the statute's validity." And "where a statute is susceptible of two differing constructions – one which will render it constitutional and the other which will not – the former construction will be adopted if it can reasonably be done," according to *In re Tingle*.

Of course, the General Assembly may not enact legislation that erodes the fundamental core of the judicial power. For example, the Legislature may not "pass a statute in an attempt to change the result of a decision which has been finally decided as between the parties to that case," according to *Sanelli vs. Glenview State Bank*. Such a law would unduly infringe upon the exclusive judicial power to decide cases and controversies, and "the judiciary must be unimpeded in considering and rendering judgments," according to *O'Connell vs. St. Francis Hospital*. "The power to adjudge, determine and render a judgment is beyond all question a judicial act, and can only be employed by judicial authority. The Legislature cannot direct the judiciary how cases shall be decided," according to *Agran vs. Checker Taxi Co.* Likewise, the General Assembly "cannot enact statutes solely concerning court administration or the day-to-day business of the courts," according to *People vs. Williams*. Nor can the Legislature pass a law that directly and irreconcilably conflicts with a Supreme Court rule, according to *People vs. Walker*.

But the scope of "exclusive" or "inherent" judicial powers is not expansive, and it is well-established that "the Legislature may, consistent with the separation of powers principle, impose requirements governing matters of procedure and the presentation of claims," according to the *DeLuna* case. Pursuant to this concurrent authority, the General Assembly has enacted, and the Supreme Court has upheld, statutes "complementing the authority of the judiciary" or having "a peripheral effect on judicial administration," according to the *Williams* case. Statute permitting substitution of judge "only peripherally affects the role of the judiciary and therefore does not violate separation of powers," the *Williams* case stated. The General Assembly also

unquestionably "has the inherent power to repeal or change the common law, or do away with all or part of it," according to *People vs. Gersch*. Finally, the General Assembly may enact legislation "which changes the effect of a prior decision of a reviewing court with respect to others whose circumstances are similar but whose rights have not been finally decided. This power extends to decisions in which the law changed by the Legislature resulted from a reviewing court's interpretation of a statute as well as from a reviewing court's interpretation of the common law," according to the *Sanelli* case.

With these principles in mind, it should come as no surprise that Illinois courts historically have made every effort to avoid invalidating legislative enactments or substituting their views for those of the General Assembly on matters of public policy. As the court declared in *Roanoke Agency Inc. vs. Edgar*, "When the Legislature has declared, by law, the public policy of the state, the judicial department must remain silent, and if a modification or change in such policy is desired, the lawmaking department must be applied to, and not the judiciary, whose function is to declare the law but not to make it."

"As a reviewing court, we would be usurping a legislative function if we were to analyze statistics and decide that the Legislature, in our opinion, incorrectly interpreted them. Our role is not to determine how wise legislation may be, but rather to determine its constitutionality," according to *People vs. J.S.*

The tort reform legislation encompassed numerous such public policy judgments by the General Assembly that are entitled to deference from the Illinois courts: liability should be imposed in proportion to fault; noneconomic damages should be rational and predictable, rather than speculative; both sides in bodily injury cases should have early and equal access to relevant medical records, and so on. Notwithstanding the efforts of the plaintiffs' bar to manufacture a separation of powers problem, these reforms neither interfere with the courts' core adjudicatory functions nor conflict with any Supreme Court rule. Accordingly, no separation of powers problem exists with respect to the Illinois tort reform legislation.

Nor is there any constitutional difficulty under the equal protection, due process and special legislation clauses of the state constitution. Legislation passes muster under these related doctrines if any conceivable rational basis can be articulated for it. As

Justice Douglas explained, applying the identical federal standard, in *Williamson vs. Lee Optical of Oklahoma*: "The law need not be in every respect logically consistent with its aims to be constitutional. It is enough that there is an evil at hand for correction, and that it might be thought that the particular legislative measure was a rational way to

These reforms
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with the courts' core
adjudicatory
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Court rule.

(Continued on page 10)

The question is

(Continued from page 9)

correct it. The day is gone when this court uses the due process clause of the 14th Amendment to strike down state laws, regulatory of business and industrial conditions, because they may be unwise, improvident or out of harmony with a particular school of thought."

Under an evenhanded application of this standard, it is preposterous to conclude that no rational basis existed for the General Assembly's decisions to institute a uniform cap for noneconomic damages, to require that courts impose liability only

in proportion to fault and to allow defendants equal and timely access to plaintiffs' medical records and treating physicians. This is not to say that competing policy interests are not at stake or that other legislative outcomes also would not be rational. It is to say, however, that the policy choices made by the General Assembly fully comport with the constitutional mandates of equal protection and due process, and do not run afoul of the prohibition on special legislation.

The tort reform appeals involve the application of well-established constitutional principles. Under these principles, the General Assembly's judgments as to

the broad public policy issues of civil justice reform are entitled to a strong presumption of validity, and the Supreme Court should uphold them if it faithfully follows its own well-settled precedents. In the trial courts of this state, plaintiffs have distorted both the intent and effect of the tort reform legislation and the principles of constitutional law under which the legislation is to be reviewed, hoping to create "a kind of hydraulic pressure which makes what previously was clear seem doubtful, and before which even well-settled principles of law will bend," according to *Northern Securities Co. vs. United States*. Under the

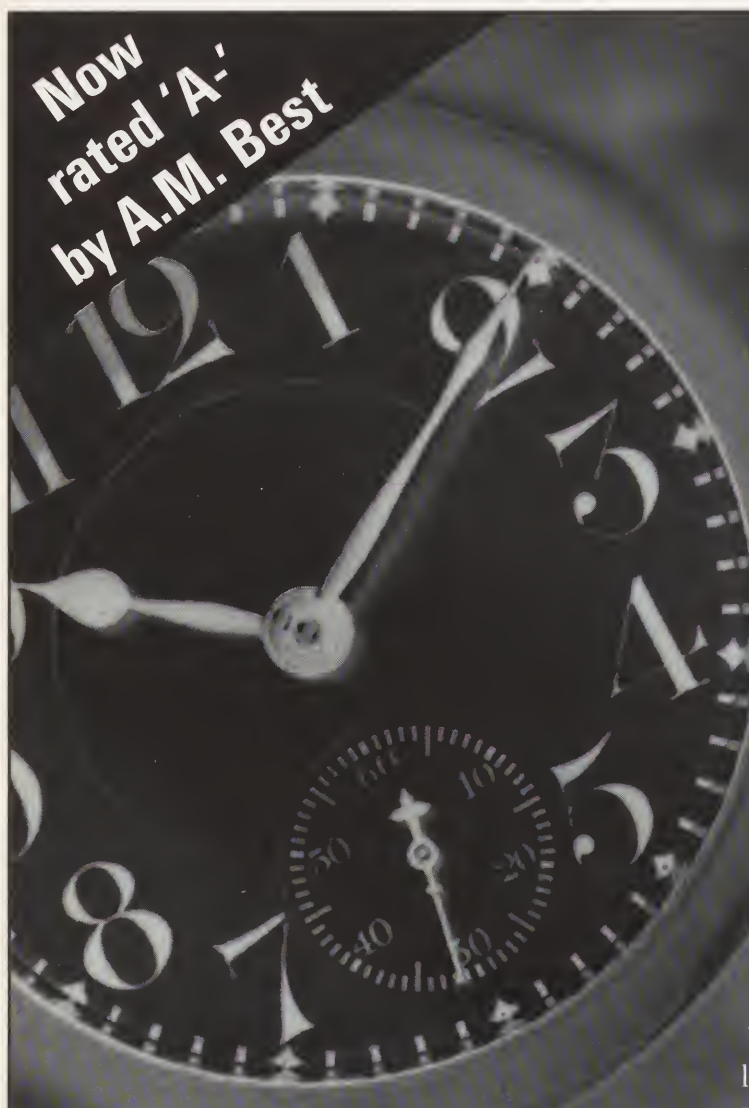
weight of this pressure, the circuit courts have completely disregarded the carefully constructed framework of constitutional analysis outlined above, relying instead on their own notions of public policy to invalidate in its entirety the most significant piece of legislation enacted this decade by the General Assembly.

The trial court decisions striking down the Illinois tort reform legislation suggest a misguided attempt to substitute the policy preferences of the judiciary for those of the Legislature, as the Supreme Court of the United States frequently did during the now-discredited "Lochner Era." Under a proper conception of the separation of powers, as the Illinois Appellate Court has written, judges may not "substitute [their] judgment for that of the Legislature" and "step backward in time to what has been described as the 'Lochner Era' of judicial intervention in the legislative process," said *Anderson vs. Wagner*. Just last year, in fact, the Supreme Court of Illinois expressly disapproved of this brand of judicial activism in a school financing case, quoting the views of a Washington Supreme Court justice who "lamented the court's usurpation of the legislative prerogative in the area of educational policy" in words that apply equally in the tort reform context: "If their legislators pass laws with which they disagree or refuse to act when the people think they should, they can make their dissatisfaction known at the polls. They can write to their representatives or appear before them and let their protests be heard. The court, however, is not so easy to reach, nor is it so easy to persuade that its judgment ought to be revised. A legislature may be a hard horse to harness, but it is not quite the stubborn mule that a court can be. Most importantly, the court is not designed or equipped to make public policy decisions, as this case so forcibly demonstrates," according to the Committee for Educational Rights vs. Edgar.

Whether the issues involve wages and hours (as in the *Lochner* Era) or tort reform (as in the present day), the Legislature has pre-eminent responsibility for deciding matters of public policy. This wise and longstanding division of power between the branches works. For example, in *Charles vs. Seigfried*, the Supreme Court declined to judicially expand civil liability to social hosts who serve alcoholic beverages to minors on the ground that responsibility for determining whether such a cause of action should exist lies with the General Assembly. Subsequently, the General Assembly has passed legislation that would impose "liability for social hosts who provide alcohol to guests who cause injury, thereby responding to the Supreme Court's decision in *Charles*," according to the *Chicago Daily Law Bulletin*.

The Supreme Court likewise should defer to the General Assembly on the public policy issues relating to the reform of the Illinois tort system. Those who believe that tort reform is bad public policy likewise "must resort to the polls, not to the courts" for a remedy, according to *Munn vs. Illinois*. ■

*Muench and Dow are appellate litigators with the Chicago law firm of Mayer, Brown & Platt. They filed amicus briefs on behalf of the Illinois Civil Justice League in *Kunkel vs. Walton and Best vs. Taylor Machine Works et al.**



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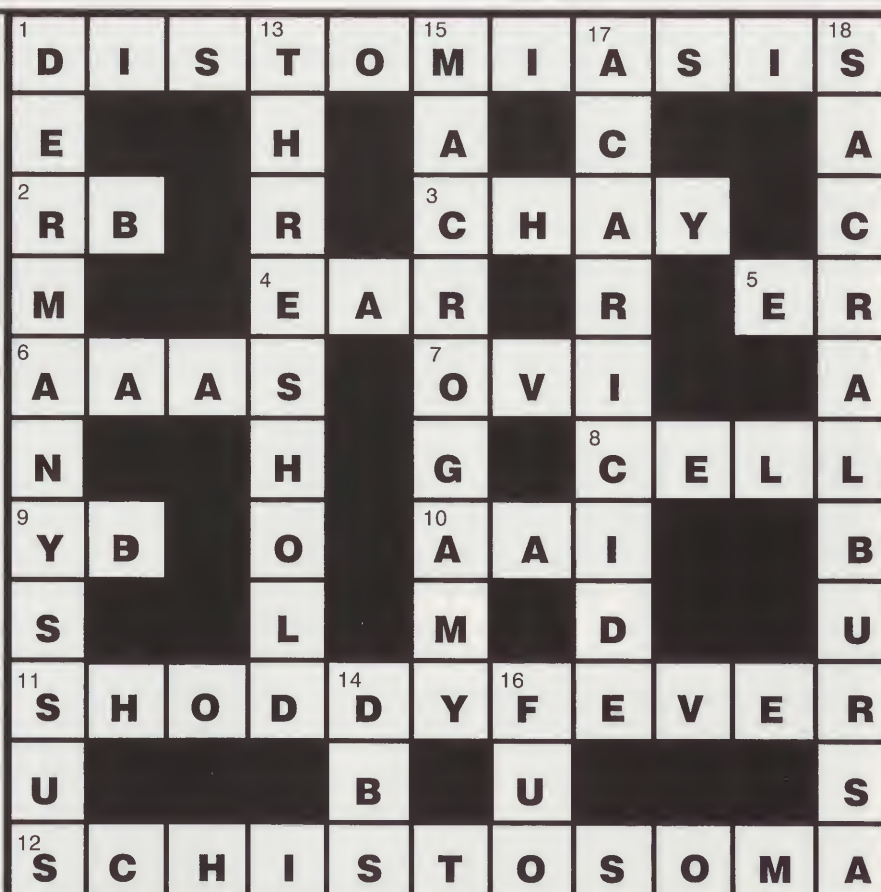
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Physicians testify

(Continued from page 1)

reverse health care savings and benefits many Illinois residents now receive from managed health care plans," wrote Patricia Wilson-Holden, assistant vice president of the American Insurance Association, in a letter to the committee.

Bruce Douglas, MD, a former state legislator who sponsored the bill creating Illinois HMOs in the early 1970s, testified that the bill's intent was to establish an organized medical care delivery system with the family physician overseeing patient care. He said, "Managed care has been responsible for taking a disparate nonsystem of health care delivery and placing the emphasis where it is most needed – on prevention, on early detection and intervention, on regular checkups, on inoculations for children and on disease management."

But some physicians noted that despite claims to the contrary, quality has at times been sacrificed for cost. For example, patients find themselves paying the bill for emergency department care, because their HMOs advise them to stay home despite alarming symptoms, physicians testified. If the HMOs refuse to pay the bill, patients may be reluctant to return to the emergency department even if their symptoms warrant a visit.

"In many cases, managed care plans have created administrative and financial barriers that prevent patients from getting the care they need in an emergency," said Susan Nedza, MD, the president of the Illinois College of Emergency Physicians. "These practices not only endanger patients' health, they threaten to undermine the entire emergency care system by failing to pay a fair share to maintain this vital public service."

A prudent layperson definition would help resolve this access problem, Dr. Nedza said. According to this definition, plans would cover patients' emergency department visits if a reasonable and prudent person would have perceived that an emergency existed. Although many plans are working to resolve this problem, "changes will come slowly," she said. "ICEP believes that Illinois legislation in this area is imperative."

Access was also a concern for the Illinois Dermatological Society. Almost 30 percent of Americans have some type of skin disorder, and studies have shown that dermatologists are more effective in diagnosing and treating those disorders, said Marianne O'Donoghue, MD, an Oak Brook dermatologist who spoke on behalf of the society.

John Schneider, MD, president-elect of the Illinois Society of Internal Medicine, talked about chronically ill patients who find their treatment bogged down in the managed care referral process. For example, cancer patients with complex care handled by specialists must have their treatment plans reapproved every 30 to 45 days, Dr. Schneider said. "Does it make any sense for me to try to judge whether the chemotherapy they're getting is correct or not?" he asked.

The answer is to allow principal care providers, Dr. Schneider said. "These are individuals with specialized training who should be able to assume responsibility

for care of patients with serious, acute or chronic illnesses without the necessity of those patients repeatedly going to a primary care gatekeeper."

Although critics have raised concerns about cost, strict preauthorization doesn't always save money, according to Dr. Schneider, who also is the director of utilization review for the University of Chicago Hospitals. He said, "I know of organizations that have looked at the cost ineffectiveness of their preauthorization programs in which they've discovered they're spending more money than they're saving in terms of eliminating 'unnecessary or inappropriate' care." ■

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Lawsuit settlement

(Continued from page 1)

physicians as part of hospital medical staff credentialing. The HOD position also states that medical staffs should have authority over substance abuse policy and procedures covering pre-employment, credentialing and other phases of physician evaluation, and that drug testing for physicians should be based on reasonable suspicion and include substantive and procedural due process safeguards.

Theodore Kanellakes, MD, chairman of the ISMS Organized Medical Staff Section, said he believes that a hospital policy that allows physicians on medical staffs to discreetly reach out to help a troubled colleague is the best way to handle drug and alcohol abuse among doctors. "Physicians are human, too. Helping them can be done quietly when there is a blip in their personal lives, without ruining their careers."

Drug and alcohol testing wouldn't deter physicians from substance abuse, said Dr. Kanellakes, who also serves on the bylaws committee at St. Joseph Medical Center in Joliet. "If you test once a year, doctors will stop using several days before testing," he said. "If you have random tests, doctors who abuse will still fall through the cracks."

Although specific regulations vary, Illinois hospitals in general rely on the physician members of medical staffs to monitor themselves and their colleagues for drug and alcohol abuse, according to the Illinois Hospital and HealthSystems

Association, based in Naperville.

Medical staffs have "self-policing mechanisms that are pretty similar and that encourage whistle-blowing and encourage impaired physicians to seek help," said IHHA spokesperson Bettina Finch. The drug and alcohol abuse monitoring is "really more of a medical staff issue than a hospital issue."

St. John's Hospital in Springfield has no requirements for pre-employment drug testing or random drug test requirements for physicians or other health professionals who work at the hospital, said a hospital spokesperson. But physicians who are known to have a problem may be asked to take a drug test.

Memorial Medical Center, also in Springfield, has a similar policy. Neither physicians nor other health care professionals employed at the hospital are required to take pre-employment drug tests or submit to random screenings, said Cindy Appenzeller, Memorial's medical staff coordinator.

There are ways to get information about drug and alcohol use other than through mandatory drug testing, Appenzeller said. For example, physicians applying for employment with the hospital are asked on the application if they have medical problems that would interfere with their ability to deliver medical care. A physician who responded by mentioning previous marijuana use was asked to take a drug test, Appenzeller said. Because individuals with drug or alcohol abuse problems are considered to be disabled according to the Americans with Disabili-

ISMS helps members with substance abuse problems

Assistance for ISMS members with drug or alcohol problems is a telephone call away thanks to the ISMS Physician Assistance program, which is overseen by the ISMS Physician Assistance Committee.

The program has been designed to help physicians who have experienced problems with alcohol or drug abuse, or the effects of aging, stress, psychiatric disability or other impairments. Those who request help can be directed to a treatment program through which they can be diagnosed and monitored and get therapy.

The Physician Helpline, (312) 580-2499, is often the first link to the Society's program. The helpline may be

used by physicians who recognize their own substance abuse problem or by other concerned individuals, such as colleagues, hospital administrators, family members, friends or patients. The calls are handled by physicians.

All allegations are investigated and the identity of the reporting caller isn't revealed without permission. If the allegations are substantiated, a team of volunteer physician intervenors work with family members, colleagues and other interested individuals to motivate the physician to participate in a treatment program. Recovering physicians are asked to sign an agreement with the Physician Assistance Committee that commits them to monitoring programs.

ties Act, the hospital cannot ask specifically about past use, she added.

As required by federal law, Memorial contacts the National Practitioner Data Bank to check for malpractice complaints filed against physicians who apply for appointment to the hospital's medical staff. In addition, the hospital conducts background checks with all other hospitals where the physician was on staff, Appenzeller said.

At Rush-Presbyterian Medical Center in Chicago, only physicians who are hospital employees are required to undergo pre-employment drug screenings, said spokesperson Denise Van. Those tests

are standard for all prospective employees, she said.

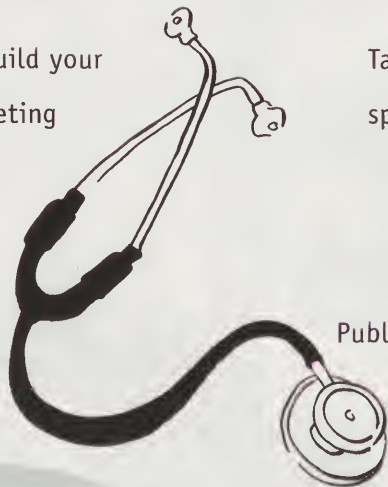
Hospital policies that allow medical staffs to self-police for drug and alcohol abuse seem to work well, Finch said. No incidents similar to the case in Texas have occurred in Illinois, she noted.

But the AHA's Wade said he thinks South Park Hospital's settlement signals that something is flawed with the hospital's policy. He said, "Most policies require physicians to turn themselves in or to report a colleague, but, obviously, others knew about the problem of the doctor in Texas, and that didn't take care of the problem."

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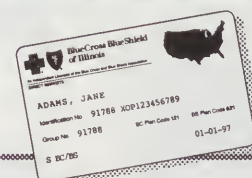
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PAGE 7

Illinois Medicine

ILLINOIS STATE MEDICAL SOCIETY • SEPTEMBER 26 1997

Gov. Edgar signs
telemedicine,
staff privileges
bills

PAGE 3

New federal law includes incentives for physicians

MEDICARE: Reforms
allow for creation of
PSOs. BY JANE ZENTMYER

[WASHINGTON] Congress and President Clinton have captured headlines with a 1998 federal budget that trims \$116.4 billion from Medicare during the next five years, including \$5.3 billion from the physician line. But some changes in the new law offer physicians and their patients an opportunity to benefit from the Medicare reforms.

"A number of helpful patient protections, along with constructive provisions for developing provider-sponsored organizations, form part of the agreement," said AMA President Percy Wootton, MD. "These are crucial quality-assurance provisions, since they enhance and protect the physician-patient relationship."

Those provisions are part of Medicare+Choice, or Medicare Part C, which consolidates all managed care options for Medicare enrollees. Medicare Part C allows for the creation of provider-sponsored organizations, or PSOs, to offer Medicare+Choice.

The law defines PSOs as public or private entities created by a health care provider or group of affiliated health care providers who provide a substantial proportion of the providers' health care items or services. Calculations for a "substantial proportion of health care items or services" take into account such factors as the need to contract with unaffiliated providers for limited services, as well as organizational differences such as rural or urban locations, according to the ISMS analysis. The providers must also share substantial financial risk and must have at least a majority financial interest in the PSO.

The PSOs can apply for a waiver that will allow them to postpone state licensure for three years, according to an ISMS analysis. The waiver also

(Continued on page 10)

Illinois House tackles physician-assisted suicide

HEARING: ISMS and the AMA testify against legalization in Illinois. BY JANE ZENTMYER

[CHICAGO] Physicians must stay in the healing business, "and not cross the line to assisted suicide," ISMS President Jane Jackman, MD, told lawmakers attending a hearing on physician-assisted suicide Aug. 28. "Sometimes patients will ask physicians to cross that line, posing difficult ethical situations that few feel prepared to handle. But I don't think that means we should abandon our principles or weaken our laws." The hearing was held by the Illinois House's Judiciary Criminal Law Committee as part of its consideration of H.B. 691, which would legalize physician-assisted suicide.

A physician who faced a situation she felt unequipped to handle also testified. Linda Emanuel, MD, the AMA's vice president of ethical standards, told the committee about a request from a young breast cancer survivor who expected her disease to recur. Although Dr. Emanuel said she wasn't trained to handle that type of request, she presented some end-of-life scenarios to the young woman. The patient real-

ized she could remain comfortable and dignified if the cancer recurred and subsequently dropped her request. "She now denies that she ever wanted physician-assisted suicide," Dr. Emanuel said. "And she's right. She didn't. She wanted control. She wanted compassion. She wanted dignity and she found it."

H.B. 691, sponsored by Rockford Democrat Rep. Douglas Scott, would limit physician-assisted suicide to terminally ill patients, with safeguards such as a two-week waiting period put in place to prevent abuse.

On June 27, the U.S. Supreme Court ruled that physician-assisted suicide is not a constitutional right, but the decision doesn't preclude states from legislatively allowing the practice. The AMA, with ISMS and 50 other groups signing on,



Dr. Emanuel

filed an amicus brief opposing the legalization of physician-assisted suicide.

"The doctor's traditional role in society is that of healer and comforter," Dr. Jackman said. "Allowing physicians to

legally assist patients in the deliberate taking of their own lives will subvert that role and undermine the trust that forms the very cornerstone of the doctor-patient relationship. Ultimately, we believe, that's going to result in erosion of the quality of health care available to all our patients."

Organized medicine is working to improve care for terminally ill patients. The AMA launched a program in March to help physicians provide quality care to dying patients, Dr. Emanuel said. Dr. Jackman added that ISMS will work with a new Senate task force to study current Illinois law dealing with the terminally ill, with a report to be issued in January.

Assisted-suicide supporters argued that the real issue is per-

(Continued on page 8)

IDPH postpones Hepatitis B requirement to increase kids' compliance

IMMUNIZATION: State also expands timing between second, third shots.
BY JANE ZENTMYER

[SPRINGFIELD] On Aug. 15, the Illinois Department of Public Health announced a one-year delay in its enforcement of a required Hepatitis B vaccination for children entering fifth grade this year and all youngsters over the age of 2 who are enrolled in prekindergarten programs. The requirement was scheduled to go into effect this school year.

"Due to the complexity of the new mandate, which involves three separate visits to a health care provider over several months, it was decided a one-year delay will allow parents greater opportunity to have their children immunized according to the recommended vaccination schedule and not force their exclusion from school," said IDPH Director John Lumpkin, MD.

IDPH officials also announced a change in the timing of the second and third shots in

the three-shot series. Previously, IDPH required a minimum of two months between the second and third inoculations, but the gap was increased to three months. The first and second shots must still be given four weeks apart.

Studies have shown the vaccine is more effective if the last two shots are at least three months apart, said IDPH spokesperson Tom Schafer. Physicians may use their discretion to space the last two inoculations as much as six months apart, as some drug manufacturers recommend, Schafer explained. Children immunized this year with the two-month

timing do not need additional shots to fulfill the new immunization requirements.

Schafer said the department is concerned that some parents may try to compress the time between shots to speed compliance, and they may do that by going to a different physician or clinic for each shot. But if youngsters fail to get the last two shots at least three months apart, the vaccine's effectiveness could be only 70 percent, Schafer said.

IDPH estimates that at least 60 percent of Illinois' 2-year-olds have already received the Hepatitis B shots, because the

(Continued on page 10)

INSIDE

Settlement
supports state on
milk labeling

MOO!

PAGE 2

Getting consent
to treat foster
children

PAGE 6

DEPARTMENTS

Malpractice
Roundup.....6

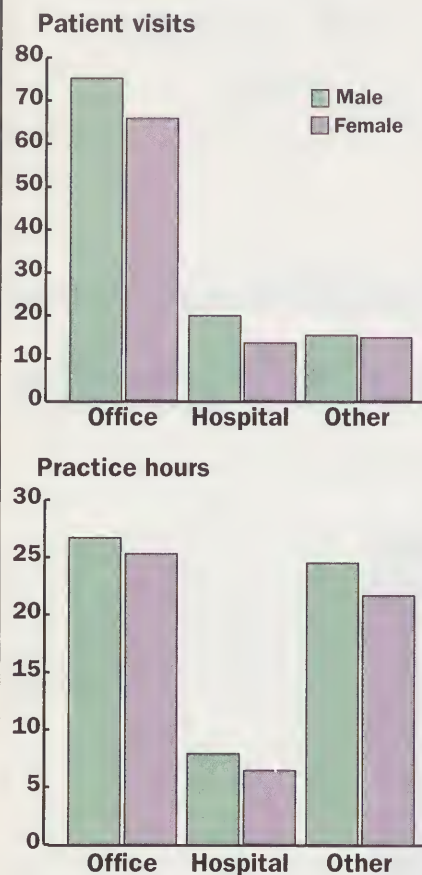
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Practice characteristics

Average patient visits and practice hours per week (excluding residents), 1995



Source: AMA Center for Health Policy Research Socioeconomic Monitoring System, core surveys, 1995 and 1996

Settlement supports IDPH position on milk labeling

[SPRINGFIELD] A recent legal settlement supported the Illinois Department of Public Health's position barring unsubstantiated claims printed on milk product labels. The lawsuit arose from IDPH's refusal of a request last year by three dairy companies to allow labeling of their products sold in Illinois as "rBGH-free." Recombinant bovine growth hormone is a synthetic version of BGH, a hormone that occurs naturally in cows and stimulates milk production. IDPH refused the dairy companies' request to use rBGH-free labeling on the grounds that there is no laboratory test to verify that milk was produced without use of the synthetic hormone. In response, the dairy companies sued IDPH in U.S. District Court.

"Our labeling law requires a manufacturer to be able to prove what was on their label," said IDPH spokesperson Tom Schafer. "Until there is some sort of test that can differentiate between the natural BGH that is in a cow vs. the synthetic hormone, we will not allow rBGH-free labeling in our state. Consumers need to know what's in their food, and manufacturers can't produce any test that will say that it is rBGH-free."

The companies involved in the suit — Ben & Jerry's Homemade Inc. of Burlington, Vt.; Stonyfield Farm of Londonderry, N.H.; and Organic Valley Farms of LaFarge, Wis. — wanted to include the phrase rBGH-free on their

labels. Under the settlement, they may state, "We oppose rBGH. The family farmers who supply our milk pledge not to treat their cows with rBGH." The label must also say, "The Food and Drug Administration has said no significant difference has been shown and no test can now distinguish between milk from rBGH-treated and untreated cows."

"We took a fairly hard stance, and in the end our consumers in Illinois are protected from something that would be misleading," Schafer said. "Under this

settlement, the manufacturers are allowed to put what I would call a political statement on their labeling, which they felt was their First Amendment right. We had no problem with that, but beyond that statement, they must also have the additional language."

IDPH grappled with the issue of rBGH-free labeling when farmers from Wisconsin, which allows labeling containing the controversial statement, tried to sell products carrying those labels in Illinois. "Where they have tried to sell products with those types of labels, we have embargoed them and sent them back," Schafer said. ■

State requires information on new employees

[SPRINGFIELD] All employers, including physicians, are required to report the names of new employees to the Illinois Department of Employment Security within 20 days of their start dates to comply with a new program to track down deadbeat parents. The rule becomes effective Oct. 1.

According to the employment security department, the reporting program was created in 1996 by Congress to help find absent parents and, in some cases, establish paternity and enforce child support orders.

Data can be reported on a preprinted IDES form; a legible copy of the employee's W-4 form, including employer information; a computerized listing of all new employees; or a twice-monthly electronic

or magnetic data submission. In all cases, the state needs the employees' names, addresses and start dates, as well as the employers' names, addresses and federal employer identification numbers.

Information may be mailed to the Illinois New Hire Directory, P.O. Box 19473, Springfield, IL 62794-9473, or faxed to (217) 557-1947. For more information, call (800) 327-HIRE. ■

Correction

In the Aug. 29 issue, the Illinois Department of Insurance's Web site address was incorrect. E-mail should be sent to www.state.il.us/ins.

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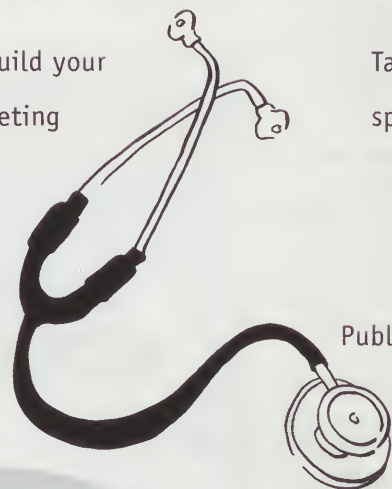
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Governor signs health-related bills

ACTION: Definition of telemedicine, protection for abuse victims become Illinois laws. BY JANE ZENTMYER

[SPRINGFIELD] As summer ended, Gov. Jim Edgar was busy completing his review of bills sent to him during the spring session. Edgar signed the following ISMS-supported bills:

DEFINING TELEMEDICINE

S.B. 314 defines telemedicine and sets forth injunctive remedy and criminal penalties for practicing telemedicine without a medical license.

Telemedicine is defined as a written or oral opinion about an Illinois patient's diagnosis or treatment that is conveyed via telephone or electronic or other types of transmission. The law excludes periodic consultations between a licensed Illinois physician and someone outside the state, second opinions provided to physicians and follow-up diagnoses or treatments if the Illinois patient was initially treated in the state where the original physician is licensed.

M. LeRoy Sprang, MD, chairman of the ISMS Board of Trustees, wrote to the governor in support of the bill: "We support the growth of communications technology and its appropriate use to service the medical needs of Illinois citizens. However, we also feel it is important to ensure that the physicians providing these services meet the licensure standards established for Illinois physicians."

Sponsors were Rep. Raymond Poe (R-Springfield) and Sen. Kathleen Parker (R-Northfield).

MEDICAL STAFF POSITIONS, PRIVILEGES

S.B. 234 allows members of a hospital district medical staff to hold at least one director's seat on the hospital district board. ISMS helped develop the legislation, which was sponsored by Sen. Todd Sieben (R-Geneseo) and Rep. Ronald Lawfer (R-Freeport).

The governor also signed an ISMS-supported bill that defines medical staff privileges in the Hospital Licensing Act as permission to provide medical or other patient care services and to use existing hospital resources, such as equipment and personnel, that are necessary to provide those services. Lead sponsors of this bill, H.B. 408, were Reps. Miguel Santiago (D-Chicago) and Mark Beaubien Jr. (R-Wauconda) and Sen. William Mahar (R-Orland Park).

PROTECTING ABUSE VICTIMS

S.B. 490 prohibits licensed insurers from denying life, health or disability insurance coverage because of a history or evidence of domestic abuse.

"This legislation ensures that a com-

pany's decision to insure be based on underlying health conditions whether there is evidence of abuse or not," the governor said. The law becomes effective Jan. 1.

Lead sponsors were Sens. Robert Madigan (R-Lincoln) and Larry Bomke (R-Springfield) and Reps. Frank Mautino (D-Spring Valley) and Poe. ■

MONTRICE MCKNIGHT (center) gets a little help from Montell McKnight as she puts the finishing touches on a drawing. The two participated in the Violence Prevention Health Fair held Aug. 22 by Cook County Hospital's trauma department.



John McNulty



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REPORT for Illinois Physicians

ILLINOIS MEDICARE REFRACTIVE KERATOPLASTY - NOT COVERED

Medicare does not cover refractive keratoplasty in most cases. Refractive keratoplasty is surgery to reshape the cornea of the eye to correct vision problems such as myopia (nearsightedness) and hyperopia (farsightedness). Refractive keratoplasty procedures include the following:

- *Keratomileusis* - the front of the cornea is removed, frozen, reshaped, and stitched back on the eye to correct either near or farsightedness;
- *Keratophakia* - a reshaped donor cornea is inserted in the eye to correct farsightedness; and
- *Radial keratotomy* - spoke-like slits are cut in the cornea to weaken and flatten the normally curved central portion to correct nearsightedness.

The correction of common refractive errors by eyeglasses, contact lenses or other prosthetic devices is specifically excluded from coverage. The use of radial keratotomy and/or keratoplasty for the purpose of refractive error compensation is considered a substitute or alternative to eye glasses or contact lenses, which are specifically excluded by Section 1862(a)(7) of the Social Security Act (except in certain cases in connection with cataract surgery). In addition, many in the medical community consider such procedures cosmetic surgery, which is excluded by Section 1862(a)(10) of the Act. Therefore, radial keratotomy and keratoplasty to treat refractive defects are not covered.

However, keratoplasty that treats specific lesions of the cornea, such as phototherapeutic keratectomy that removes scar tissue from the visual field, deals with an abnormality of the eye and is not cosmetic surgery. Such cases may be covered under Section 1862(a)(1)(A) of the Act.

In addition, the use of lasers to treat ophthalmic disease constitutes ophthalmologic surgery. Coverage is restricted to practitioners who have completed an approved training program in ophthalmologic surgery.

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EDITORIAL

Hospitalists – a new import

Trendsetting California has lately exported something to Illinois besides wine, movies and produce. That export is the use of hospitalists – specialists in inpatient medicine who manage the care of hospitalized patients, allowing primary care physicians to focus on providing care primarily or exclusively in the office. These specialists, who are often internists, are especially pervasive in managed care-dominated areas like California. But recently hospitalists have cropped up in the Chicago area through Humana Health Care Plans, United Healthcare of Illinois, Suburban Lung Associates and Rush Presbyterian-St. Luke's Medical Center.

Fueling the trend is the push for greater efficiencies and cost control. The efficiencies come from the ability of outpatient physicians to care for a larger patient base while inpatient physicians can respond quickly and resourcefully to changes in patients' conditions, according to the New England Journal of Medicine. The journal reported that anecdotally, the use of hospitalists has substantially decreased lengths of stay, hospital costs and specialty consultations.

Crain's Modern Healthcare magazine interviewed some hospitalists who outlined the benefits of the model. First, doctors who know a hospital well also know its strengths and weaknesses and how to maximize the system. Patients also get more care from physicians who can monitor their progress several times

a day, which increases patient satisfaction. The base of knowledge in medicine is so expansive that generalists can't be expected to know it all, so a narrower focus makes sense. And finally, the increasing acuity of hospitalized patients results in more complications, calling for a sophisticated physician response. Some observers have noted that patients switch physicians more often in managed care anyway, so a lack of continuity isn't necessarily a problem.

But despite the pluses, some physicians are concerned. The journal article, which was positive about the benefits and the growth potential of the hospitalist model, said that some primary care physicians prefer to manage their patients through hospitalization to preserve continuity of care and their own acute-care skills. Specialists anticipate a reduced number of consultations, which has been borne out anecdotally. Some worry that the trend may even lead to a division between specialists who do and don't perform procedures.

The litmus test will be how the hospitalist model affects patient care. Hospitalized patients are at their most vulnerable and deserve the best care possible. Adding another person into the mix of caregivers means that communication is more critical than ever.

ISMS policy has always been that physicians must act as patient advocates first and foremost. It's too soon to tell how the use of hospitalists will affect patients.

PRESIDENT'S LETTER

'Pavane for a Dead Princess'

Jane L. Jackman, MD



We have a responsibility to all our patients to ask about their alcohol use, no matter how distasteful that may be to us.

Debussy's "Pavane for a Dead Princess," with its hauntingly beautiful, mournful melody, has always brought tears to my eyes. However, the only music heard during the funeral procession for Diana, Princess of Wales, was the echoing of horses' hooves on the streets of London and the intermittent tolling of Westminster Abbey's tenor bell. The sight of the horse-drawn gun carriage – carrying the red and gold, standard draped coffin – wending its three-mile course to Westminster, past 6 million mourners, made me weep. Even more tragic than the coffin, though, was the family soberly walking behind it – princes William and Harry, following their dead "Mummy" into the ancient cathedral.

All of us have been riveted by the tragedy of this senseless accident. We've even felt partly responsible for it. We are part of the public that was fascinated and dazzled by the glamour and incredible beauty of the shy schoolteacher, turned princess, turned charity worker, turned international celebrity. Maybe we allowed the paparazzi to hound her to her death. However, the real cause of death became apparent 24 hours later – an alcohol- and prescription-drug-impaired driver killed the princess. She got in the backseat of a car driven by an individual with a blood alcohol level three times the legal limit in France, the equivalent of nine shots of whiskey.

Princess Diana's death, unfortunately, is only one of hundreds of thousands of senseless, preventable deaths that happen each year when people who drink too much alcohol get behind the wheel of a car. A similar scenario is regularly played out in almost every town in Illinois, despite laws prohibiting it. We can be thankful that this year Illinois lowered the legal blood alcohol concentration from .10 percent to .08 percent, a change that reflects our House of Delegates policy. However, we also realize that any amount of ingested alcohol will somewhat impair driving skills and that a driver will be "under the influence" regardless of the

amount he or she has consumed. I believe we need to continue to lower the legal blood alcohol level, perhaps to .05 percent, which is the AMA House policy.

In 1995, drunken-driving deaths in the United States rose 4 percent from the prior year to 17,274. Preliminary figures for 1996 are steady but show an increase in the number of teen deaths. With my youngest son now taking drivers' education classes, I'm especially concerned. Since I'm still doing school and sports physicals, despite the fact that school started a few weeks ago, those numbers remind me to counsel my young patients about responsible alcohol use.

Of course, I also talk to my son about the subject, but as any parent of a healthy 15-year-old can tell you, one could have a PhD in nuclear physics and still be considered an idiot by one's own teenage progeny! Advice to teens often falls on more receptive ears when it comes from an authority figure outside the family, and we, as doctors, are in an ideal situation to do just that. In fact, we have a responsibility to all our patients to ask about their alcohol use, no matter how distasteful that may be to us. If we can prevent even one death caused by drunken driving, our efforts will have been worthwhile.

The death of the "English rose," as Elton John eulogized her, is a reminder to the world that drunken driving is a disgrace and should not be tolerated. Mother Theresa, who had met Diana, was asked to comment on her death and said, "I can't always understand God's ways, but without a doubt, this tragedy has some significance." If that significance is to increase our outrage at drunken driving, to increase education about how alcohol impairs driving skills and to encourage tougher DUI laws, Princess Diana's death won't seem so senseless. Now everyone can truthfully say, "I knew someone who was killed by a drunken driver."

GUEST EDITORIAL

Flexibility makes a difference for women in medicine

By Susan Emmerson, MD

Women in Medicine Month presents the perfect opportunity to talk about the advantages of being a woman physician and some areas for improvement. Personally, I see many more benefits than problems in being a woman physician. For instance, patients, especially children, often relate more easily to a woman.

When I finished my residency in 1987, women physicians were starting to be in demand. Maybe partly because of that, I didn't experience any put-downs, such as, "You're taking a man's spot," or "You shouldn't be here." Especially in my residency, I was often the only female, but I didn't face discrimination or harassment. Although I'm an otolaryngologist, and only about 10 percent of physicians in my specialty are women, I've been lucky to work with men and women who've helped me along in my training and my practice.

I think that the way women physicians are perceived depends on the individuals who are perceiving and being perceived. In general, if women physicians do their work, are good at what they do and do their share, they're perceived well.

People's opinions of women physicians may be partly based on their experiences in working with other women. That has worked in my favor. During my training, for example, I was preceded by a woman who was very competent and well-liked, so people were predisposed to think that I would be the same. It's great that women are paving the way for one another.

Another benefit of our profession that is especially helpful to women is flexibility. Many group practices have maternity policies in place and opportunities for job sharing.

All professional women face challenges in balancing child care and other family responsibilities with their jobs, but doctors have leeway. If I have to pick up my kids a little early or take an afternoon off for a school program, I feel free to say, "OK, no surgery that afternoon," and it's my business. If I had a job where I had to be at a certain place at a certain time and no flexibility, I couldn't do it. But I have the opportunity to juggle my schedule around my family.

My partners, who are men, are fine with that. Many women physicians have partners who understand what it's like to have a sick child or a school program. My partners, for example, are actively involved with and devoted to their own families, and they understand that family is a priority for me, because it's a priority for them.

During one of my pregnancies, I had to take an unplanned leave, and I was put on bed rest for four months. A partner filled in for me and handled the extra workload. Although maternity issues may affect women more than men, men can also have medical problems that suddenly take them out of practice. It's important that we accom-

modate one another regardless of gender.

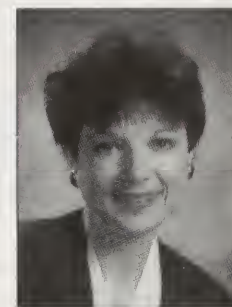
My husband, who is an ophthalmologist, and I even have options for middle-of-the-night patient emergencies, although those occasions are rare. When my husband has been out of town and I've been called to the hospital, I just packed up the kids in their pajamas and brought them with me. The kids handle that just fine, and everybody at the hospital is accommodating, too.

Although the profession is going well for women in most areas, I think we should work at attracting more women to participate in organized medicine. To do that, though, we need to make it worthwhile for women to join by offering them information that they need — help for handling practice situations, personal and practice finances, and children, for instance.

At organized medicine meetings, we could also make the logistics easier. We could provide child care at the meetings and have family-friendly activities planned. At meetings I've attended, some of the most popular events are the ones that include children and spouses. You really get to know people on a different basis when they're in a casual, relaxed setting with their families.

For women going into medicine, my advice is to cultivate enthusiasm

because then you'll be able to overcome anything. In addition, be prepared to throw yourself 110 percent into your residency and practice and 110 percent into being a wife and mother. That need to prioritize family and professional demands has the potential to create internal conflict. But everything is easier when you have flexibility and the ability to be in control, and once you're in practice, you'll have both.



Dr. Emmerson is an otolaryngologist in Bloomington and a member of the Society's Council on Public Relations and Membership Services.

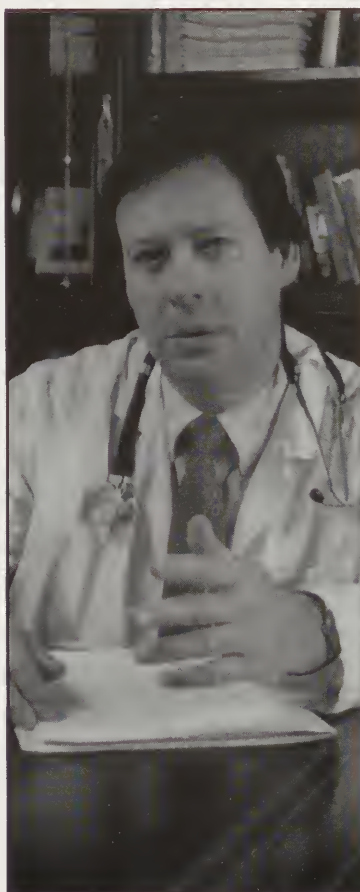
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ISMIE Update

Getting consent to treat foster children

Physicians need to know what to do in routine, major medical and emergency situations.

BY MINDY KOLOF AND DAVE WIETHOP

If a foster child arrives at your office or the hospital for medical care that requires consent, who can give it? That depends on the situation.

Part of the complexity stems from the type of custody awarded in a foster care situation. "A judge could award the state temporary custody without consent for medical care. Even though the child is in foster care, the parents could retain that right for consent for ordinary and routine care," said D. Jean Ortega-Piron, guardianship administrator for the Illinois Department of Children and Family Services, office of the guardian. "The state could be awarded temporary custody with major medical, which would include routine medical care. Or we could have guardianship, which includes the right to consent for major medical, and yet the parents still retain some residual rights."

Through the DCFS HealthWorks program, foster parents can obtain blanket consent for "routine and ordinary" medical health care like the flu or earaches. "With HealthWorks, foster parents can give consent for



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ordinary and routine care – the check-ups, the physicals for school – so that they have something with my name as guardian to consent, so the care won't be held up while consent is being sought. Also, it prevents backup here in the guardian's office," Ortega-Piron said.

DCFS gives foster parents a list of doctors who have agreed to serve as primary care physicians for these youngsters.

"These doctors have usually worked within our system and have been trained to know what to look for in terms of consent and other issues," Ortega-Piron said.

Consent becomes more complex with major medical care. The guardianship administrator is responsible for providing consent for major medical procedures such as insertion of tubes, surgical or psychiatric treatment,

specialty care, removal from life support and use of Do Not Resuscitate orders for thousands of foster children, 31,000 of whom live in Cook County.

The guardian's office receives hundreds of consent requests daily on major medical cases, and the team must prioritize cases, Ortega-Piron said. "We will call the child's physician and ask what's going on, so we can make an informed decision. In some cases we'll call our physician consultants and present them with the case."

Ortega-Piron is assisted by a network of more than 400 authorized agents in regional and field offices and in the Chicago centralized consent unit. These individuals have signatory authority and act as Ortega-Piron's agents in consent-giving functions.

When foster parents accept children into their homes, they receive information on how to contact these agents if a major medical problem arises, said Patricia Maguire, assistant guardianship administrator for the DCFS office of the guardian. For foster children in private agencies in Cook County,

which represent about 70 percent of the total, hospitals and medical providers should contact the guardianship consent team. The after-hours consent hot line is (773) 989-3450. In counties other than Cook, major medical consent for foster children in the care of DCFS or private agencies is handled by authorized agents, and foster parents are advised to contact the local DCFS office.

What happens if the foster parent erroneously gives consent? "The office of the guardian won't give retroactive consent," Maguire said. "We will, however, give consent for ongoing treatment of the child after that."

Emergency care doesn't require consent, as described in the law governing minors' consent to medical procedures, according to attorney Pat Foltz of Lord, Bissell and Brook in Chicago. The only debatable point is what constitutes an emergency. "We usually interpret this to mean a risk of specific injury to the patient if treatment is delayed in order to obtain consent."

The bottom line for physicians is simple, according to Foltz. "If in your gut you feel that the child should not walk out of your office without receiving care, document it as an emergency and treat the child." ■

MALPRACTICE ROUNDUP

New Jersey court adopts enhanced standard in HIV

The New Jersey Supreme Court ruled that a cleaning woman could sue three doctors for the emotional distress she suffered while waiting to see if she would contract AIDS. The woman had been cut by a lancet improperly thrown into the trash, according to the July issue of *Medical Malpractice Law & Strategy*.

Several courts have used the reasonableness standard, which allows individuals to recover for emotional distress based on the fear of AIDS without showing an actual exposure or a viable channel of transmission. But others have required proof of actual exposure to HIV or even demonstrations that the virus could be contracted under circumstances identical to the exposure, according to the article.

In the New Jersey case, *Williamson vs. Waldman*, the state high court said the reasonableness standard fails to address the prevalence of misinformation and ignorance about HIV infection. The high court established an "enhanced reasonable person standard," whereby an individual claiming emotional distress based on the fear of disease must show that the defendant's negligence caused substantial emotional distress that would be experienced by a reasonable person of ordinary experience who has "knowledge of then-current, accurate and generally available public information about the causes and transmissions of AIDS."

The high court also ruled that the defendant physicians were not liable for mis-

information about HIV and AIDS given to the woman by her treating physician, and that her "window of anxiety" should be limited to six months to one year.

The case has been remanded for trial on the issue of whether the woman had reasonable fear and, if so, how much the damages should be and how they should be divided among the three defendant physicians. Discovery information suggested that one of the physicians may have been responsible for the lancet's improper disposal.

Hospital liable for improper breathing tube removal

Despite defense claims that a plaintiff's brain damage resulted from an auto accident, a New York City jury found a hospital liable for improperly removing the patient's breathing tube and awarded her with \$16 million, according to the Aug. 25 edition of the *National Law Journal*.

In *Weldon vs. Beal*, a 26-year-old woman sustained facial and neck fractures during a 1985 auto accident on a New York expressway. Emergency technicians placed the woman on a breathing tube and brought her to the emergency department. The plaintiff's attorney said the patient's breathing tube was removed while she was at the hospital, and a lengthy delay before reinsertion cut off the oxygen flow to her brain, causing extensive brain damage. The woman remains semicomatose, with partial paralysis of her arms and legs.



Annie Gusman/SIS

Hospitalists specialize in inpatient care

Physicians discuss the pros and cons of a trend hitting the Midwest.

BY PATIENCE KRAMER

In the last few years, new medical specialists have cropped up: physicians who care for patients only while they're in the hospital. Then after discharge, these specialists return patients to their primary care physicians. They've been called inpatient physicians, hospital-based specialists, inpatient clinical consultants or rounders, but increasingly they're known as hospitalists. There are between 1,500 and 2,000 hospitalists now practicing in the United States, according to the National Association of Inpatient Physicians, a coalition of inpatient physicians that was launched in January.

"We're seeing more information from managed care organizations and large hospitals that are gearing up for hospitalists," said Theodore Kanellakes, MD, chairman of the ISMS Organized Medical Staff Section. "Maybe it's a good concept, yet it may be a disaster. On the medical staff side, there are serious concerns."

First observed on the West Coast and in Canada and Europe, the hospitalist concept is gaining a foothold in the Midwest. Edward Diamond, MD, of Suburban Lung Associates, a group of pulmonary and critical care physicians in Elk Grove Village, said his group began providing hospitalist services to primary care physicians two years ago. "Our specialty is particularly poised for this. We manage critically ill patients routinely, and we also have many patients who are not in the ICU but who are on the hospital floor."

Dr. Diamond said he believes the use of inpatient physicians stems from managed care, but other physicians aren't so sure. "The history of this goes to group medical practices, which have been splitting their competencies into hospital and nonhospital [care] for some time," said Kaveh Safavi, MD, vice president of medical affairs for United HealthCare of Illinois. "There are a lot of pressures rekindling it. The acuity level at hospitals is going up, as is the acuity level on the outpatient side. The levels of expertise

that people need in the hospital are [also increasing]. It's very common that primary care doctors admit patients, but specialists drive the case anyway because they're spending time in the ICU. The use of hospitalists is a realization that with the shifts in the acuity model and time constraints, doctors can't split their time between their outpatient and inpatient practices and do a good job."

Hospitals have also played a role in the trend toward hospital-focused physicians, Dr. Safavi said. He noted that some hospitals pushed for this new specialty because of such issues as inconsistent procedures for admitting patients from the emergency department. Hospitals are "trying to figure out how to improve the quality and consistency of the care. They also realize that inefficiency and inconsistency cost them money."

United HealthCare took a year to build what it calls its inpatient clinical consultant program, which was launched in July. "We talked to hospital medical staffs and group practices, asking whom they really considered the experts on inpatient care," Dr. Safavi said. In choosing hospitalists, the organization also relies on its experience with member physicians, again looking for individuals who demonstrate excellence in an inpatient setting and are located fairly close to the hospitals. The candidates go through the credentialing process for network physicians if they haven't already done so.

So far, 61 hospitals and nearly 175 physicians in Chicago, the collar counties and northwest Indiana participate in United HealthCare's voluntary program. About 80 percent are pulmonologists; 15 percent are cardiologists; and 5 percent are internists. Participating physicians work with general surgeons in the same way as any other attending physician would, according to Dr. Safavi.

The MCO doesn't assign patients to the program or physicians to specific patients. If a patient agrees to

(Continued on page 8)

Hospitalists

(Continued from page 7)

be seen by a hospitalist, the primary care physician asks a hospitalist to get involved, Dr. Safavi said. "Most primary care physicians realize that it's better for them to stay in the office and see patients, and this is why they agree to this arrangement," he explained.

Suburban Lung Associates also works through primary care physicians. Dr. Diamond said the arrangement is effective for patients and primary care physicians. "Because we are so ingrained in hospital inpatient care, we know the X-ray department and how to get laboratory tests done quickly. We are available to see the patient multiple times during the day for aggressive follow-through. We free primary care physicians to spend their time more efficiently and to focus their attention better. As a result, they are more productive and can see more patients."

Advocates of the hospitalist concept say it improves efficiency and quality of care; skeptics voice concerns about adding yet another player to an already complex mix of physicians and other health care providers.

"Continuity of care is the biggest concern that people have," said John Nelson, MD, a Florida physician who cofounded the NAIP and endorses the use of hospitalists. "Long-term continuity of care can suffer if we segregate the inpatient and outpatient caregiver because we now have introduced a new

doctor in this parade of doctors the patient sees." On the other hand, breaks in continuity occur without hospitalists, according to Dr. Nelson. "People move around; they change health plans or employers; and doctors opt in and out of health plans. A shrinking portion of our population has a long-term relationship with one physician."

Communication is critical to continuity. "Just like the specialist, the inpatient consultant knows he or she must keep the personal physician informed," Dr. Safavi said. Physicians with Suburban Lung Associates send updated progress reports to each patient's primary care physician, according to Dr. Diamond.

Hospitalists get together

In January two physicians launched the National Association of Inpatient Physicians. "We realized that these kinds of doctors were becoming more common but were not really communicating with each other," said one of the founders, John Nelson, MD, of Gainesville, Fla.

"We serve as a forum [for hospitalists] to exchange information vital to their practices such as the best ways to provide high-quality patient care, how to obtain continuing medical education credits and how to become cost-effective," Dr. Nelson said.

The association has about 900 members on its mailing list, 700 of whom are practicing hospitalists. "We'll have a membership drive this fall and formally begin to enroll physicians as dues-paying, voting members," Dr. Nelson said. The group is now looking for additional financial support from sponsors like physician-recruitment firms and pharmaceutical companies.

—Patience Kramer

Payment arrangements for hospitalists vary. Nationally, "payment takes every form you can imagine," Dr. Nelson said, adding that 50 to 60 percent are hospital employees. "Next are those who are part of a large managed care plan, and least common are those in private practice." The amount of payment also varies depending on the amount of on-call duties and the number of patients, Dr. Nelson said. United HealthCare pays a capitated rate per month to the IPA or physician group to which the hospitalist belongs. The IPA or group then pays hospitalists on a fee-for-service basis, Dr. Safavi said.

The hospitalist concept might pose a financial threat to those physicians

who derive much of their income from hospital care, Dr. Kanellakes said. But the new specialty could also take a toll on another aspect of a primary care: the sense of satisfaction in completing the cycle of care for a patient. "If you put a critically sick person in the hospital, and they respond to your care and can walk out of that hospital, there's personal gratification in that. If you're limited up to a certain point, you lose that," Dr. Kanellakes said. He added that he is concerned that physicians' skills may be compromised if they aren't involved in the more critical aspects of medicine. "You need all aspects of medicine to be a better physician."

Dr. Kanellakes said the question to ask about the use of hospitalists is, Are we doing it in the best interests of the patient, or are we doing it for economic reasons and not really looking at the patient?

The hospitalist concept is sound, Dr. Nelson maintained. "We're more accessible to patients and their families. The patient, in theory, can benefit by seeing a specialist in inpatient care. Having said that, I have no desire to do away with the current system. The patient should be free to determine which plan and doctor to use."

Patients usually accept hospitalist care, Dr. Diamond said. "When they see we care for them aggressively and efficiently and when they're assured that we work with their physician, patients usually feel quite comfortable." ■

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(Continued from page 1)

sonal autonomy and that terminally ill patients should have the right to choose how they will die. "They've concluded that their lives no longer have any meaningful quality, and after being informed of all their treatment alternatives, they see that all they have to look forward to is a prolonged dying process that is painful and expensive and degrading," said John Cirn, a founding member of the Illinois Citizens for Death with Dignity. "Please listen to them when they say, 'Enough, I've suffered enough.'"

Ulrich Danckers, MD, a retired River Forest radiologist who sponsored the 1996 AMA resolution calling for a neutral organizational stance on the issue, said, "State laws forbidding physician aid in dying have become hollow and inherently dishonest, fostering civil disobedience and causing disrespect for the law on a large scale." The AMA House of Delegates did not adopt his resolution.

Several House committee members asked if H.B. 691 would allow physician-assisted suicide for only terminally ill patients. "It's a slippery slope, and what you're creating is not just the right to die today, but the duty to die," said Rep. Peter Roskam (R-Wheaton), referring to those who may feel they should commit suicide to ease the caretaking burden on others. Current laws now act as safeguards to discourage suicide, and this bill would eliminate them, he added.

Rep. Cal Skinner (R-Crystal Lake) asked Cirn whether someone could be a candidate for state-sanctioned physician-assisted suicide if that individual wanted the money that would have been spent on nursing home care to be inherited by his children instead. Cirn answered,

"Yes, as long as he otherwise meets the requirement in this bill. Why not?"

Dr. Jackman warned the committee about such scenarios. "H.B. 691 attempts to draw a clear distinction between allowing assistance in suicide and sanctioning euthanasia. It attempts to regulate assisted suicide and limit the circumstances under which it will occur. But we believe that in practice, that distinction would inevitably blur."

Other opponents of physician-assisted suicide also refuted claims that they want to restrict personal freedoms. Rev. Francis George, archbishop of Chicago and chairman of the Catholic Conference of Illinois, explained in a letter that the conference's opposition "is rooted in our concern for our vulnerable sisters and brothers, particularly those who have no one to defend them. True death with dignity does not incorporate killing into a treatment plan." ■

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The Illinois State Hospice Organization offers the booklet "Hospice Care: A Physician's Reference Guide" to explain the hospice concept of care and the benefits that care provides to patients.

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IDPH postpones

(Continued from page 1)

vaccination has been recommended for infants since 1991, Schafer said. "By catching those [unvaccinated] 2-year-olds, we think we'll bring that up to more like 95 percent," Schafer said.

The number of fifth-graders vaccinated in anticipation of the new law won't be known until late October, Schafer said. Although fifth-graders don't have to prove they've been vaccinated this year, parents and school districts will need to show proof next year that those children, who will then be sixth-graders,

received the required Hepatitis B shots. Next year's fifth-graders will also have to show proof of their vaccination.

"We want to continue to encourage parents to get their children vaccinated as quickly as possible according to the recommended schedule," said Stephanie Smith, MD, director of communicable disease control for the Cook County Department of Public Health. "If everyone waits until next year, there's going to be double the problem in terms of the number of kids to be vaccinated." Dr. Smith estimated that between 15,000 and 20,000 Cook County children were vaccinated between January and mid-

August because of the efforts of state and county public health departments.

The one-year postponement applies only to the Hepatitis B inoculation. Children must still be immunized against seven other diseases – measles, polio, diphtheria, tetanus, pertussis, mumps and rubella – as outlined by state law. School districts that do not have at least 90 percent compliance with the immunization schedule could lose up to 10 percent of their state aid, according to IDPH. Compliance was 98.1 percent during the 1996-97 school year.

IDPH added the Hepatitis B immunization requirement to the Illinois School

Code in 1996, which brought Illinois into compliance with recommendations from the American Academy of Pediatrics and the Immunization Practices Advisory Committee of the U.S. Centers for Disease Control and Prevention. ■

New federal law

(Continued from page 1)

provides for lower solvency requirements for physicians who want to develop PSOs. Current solvency rules require providers to raise large sums of money before starting a PSO, a prerequisite that may discourage physicians from forming physician-run PSOs, according to an ISMS analyst. But the waiver reflects the fact that some providers, like physicians, could still furnish health care services to enrollees even if the PSO became insolvent.

The rules that outline implementation of the waiver haven't been developed yet. "Before they make any decisions, groups of physicians or providers interested in forming PSOs need information regarding the federal regulations and what they could do after 36 months in terms of capitalization or as the result of changes at the state level," said John Schneider, MD, chairman of ISMS' Third Party Payment Processes Committee. The groups also need an idea of the capitation rates provided for PSOs, Dr. Schneider said.

The PSO waivers will be offered in 1999, and organizations will have until Nov. 1, 2002, to request one from the U.S. Department of Health and Human Services. HHS then has 60 days to make a decision. The nonrenewable waiver is effective for three years. After it expires, the PSO must file for a state license and meet the state's solvency requirements or shut down.

ALTHOUGH THE WAIVER exempts PSOs from meeting state solvency requirements, it doesn't release them from quality-of-care or consumer-protection provisions.

In addition to providing for PSOs, Medicare+Choice also added a medical savings account option for Medicare enrollees. The option will be available from 1999 until 2003 or until the number of enrollees reaches 390,000.


Medicare+Choice organizations will be required to incorporate new consumer protections into their plans. For example, access to emergency services must be based on a prudent layperson definition, according to the ISMS analysis. Coverage must be provided for people who go to the emergency department if they experience acute symptoms that are sufficiently severe that someone with an average knowledge of medicine would expect a lack of medical attention to seriously jeopardize his or her health.

The new provisions also ban gag clauses. Medicare+Choice organizations cannot prohibit or restrict covered health care professionals from advising a patient about health status or medical care or treatment for the patient's condition or disease regardless of whether benefits for that care or treatment are provided under the plan.

Patient protections, Dr. Schneider said, are "absolutely necessary" for Medicare's population. "An elderly patient needs more protection than an employed person because there are people who prey upon them." ■

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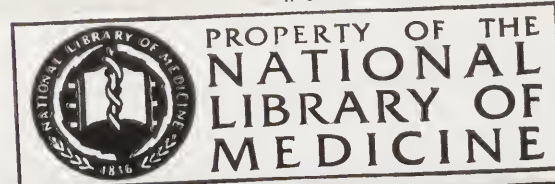
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PAGE 7

Illinois Medicine

ILLINOIS STATE MEDICAL SOCIETY • OCTOBER 10

Medicare
right-to-contract
law 'useless'



Rockford physicians form collective bargaining council

ADVOCACY: Doctors seek greater voice in patient care. BY LINDA MAE CARLSTONE

[ROCKFORD] Frustrated by the feeling that they are losing control over patient care, some Rockford physicians have launched a movement to form a collective bargaining unit at the Rockford Clinic, where they are employed. The physician group wants increased input into decision-making and actively seeks authority from the rank and file to negotiate with their employer, the Rockford Health System.

The movement is rooted in the 1994 purchase of the clinic, according to Douglas Kaplan, MD, one of seven physicians who have formed a steering committee for the group, which is called the Rockford Physicians' Council. The takeover "triggered a series of decrees from administration. It reached a crescendo when goals set out by the administration became unattainable," said Dr. Kaplan, who is also president of the Winnebago County Medical Society.



Dr. Kaplan

Rockford council organizers say control is a key concern. "We have no vote," said steering committee member Dennis Norem, MD. "The governance has not become what we had hoped it would. That's difficult for physicians to accept, especially since there's a sense of loss of control [in our profession] because of managed care and employment situations."

Dr. Norem said this sense of loss hit home with clinic physicians when they switched from being owners to being employ-

ees. "Before, we did our thing; we were major shareholders and could vote on major issues. The doctors hoped we would see a structure that would truly integrate the people in the trenches, and they just don't feel that they have that."

The council's efforts have been rebuffed by the RHS administration, which said it would rather not deal with a third party. The council said that there is no third party, just local physicians and management.

"I believe physicians will have a better chance for improvement if we work together in a partnership, rather than in an adversarial relationship," said Donald McCanse, MD, Rockford Health System's interim clinical medical director.

The council must jump two hurdles to become a certified collective bargaining agent for the clinic physicians. To hold an election, it needs approval from
(Continued on page 10)



PANELISTS DISCUSS the future of medical education at a program sponsored by the Institute of Medicine of Chicago and held in Chicago on Sept. 10. Participants were (from left) Leslie Sandlow, MD; Ralph Leischner, MD; Janis Orlowski, MD; and Michael Scotti, MD.

Numbers are up for drug licenses

CONTROLLED SUBSTANCES: Computer conversion causes state to issue new IDs. BY LINDA MAE CARLSTONE

[SPRINGFIELD] A computer conversion is causing the Illinois Department of Professional Regulation to issue new controlled substance license numbers, but officials said the state has taken steps to make the transition smooth and simple for physicians.

New controlled substance licenses printed with the new numbers were scheduled to start being mailed out the week of Sept. 29, according to Karen Dunlap, IDPR assistant program executive/licensing and testing division. The change is effective immediately, she said. A letter of explanation accompanying the licenses instructs physicians to destroy their old licenses.

Technology is to blame for the number switch, Dunlap said. The department is converting its computer system, and the new numbers were needed to accommodate the change.

Physicians are not responsible for providing their new numbers to the federal Drug Enforcement Administration or to the Department of Human Services, which was formerly the Department of Alcoholism and Substance Abuse. IDPR is

handling that notification, which will give both agencies a cross-referenced list. Physicians should, however, list their new number on the annual renewal form from the DEA when that paperwork is due, Dunlap said.

Although the license numbers are printed on physicians' triplicate prescription pads, doctors don't need to immediately order new pads, according to a spokesperson for the DHS, which uses the forms to track illegal drug prescribing. Forms with the old number can be used until they expire, he added.

The new numbers are structured completely differently from the previous ones, Dunlap said. The former numbers consisted of a prefix, followed by the physician license number and a suffix indicating where the license was held. The new licenses have a nine-digit number independent of the physician number. There will be a separate number - and license - for every location.

The expiration date of the new licenses will not change, Dunlap said. Controlled substance licenses will still need to be renewed on July 31, 1999. ■

Insurance department targets open access in HMOs

CAPITATION: Out-of-network access can pose problems in managing risk. BY TODD SLOANE

[CHICAGO] The Illinois Department of Insurance has notified two managed care entities that they are exceeding their authority under state HMO licensure by allowing HMO enrollees direct access to out-of-network specialists, according to David Grant, health care coordinator for the department.

United HealthCare of Illinois and Humana had advertised HMOs that offered open access, and both were asked by the department to pull those ads, Grant said. "The HMO statute doesn't allow out-of-network access [without a referral] for anything other than out-of-area care or emergency care."

At least one of the HMOs

has been reconstituted to resemble a preferred provider organization and preserve the open access feature.

That HMO is a United HealthCare plan called Open Access. It initially allowed patients to have direct access to out-of-network specialists while following an HMO fee schedule, a form of "managed cost." The department said it required United to stop marketing Open Access as an HMO. United has since changed the plan to a "hybrid" similar to a PPO and is marketing it as such, according to company officials.

United's traditional HMO,
(Continued on page 2)

INSIDE

Diet pills
cause feeding
frenzy



PAGE 4

Physicians
can finesse
their stress

PAGE 6

DEPARTMENTS

Malpractice
Roundup.....6

Classifieds8

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Insurance department

(Continued from page 1)

called United HealthCare Select, requires patients who want to see a non-network specialist to be referred by a gatekeeper, United officials said.

What United and Humana proposed are "HMOs that look, taste and smell like PPOs," according to Michael Vivoda, president of Chicago Health Systems Inc., a 1,874-physician IPA affiliated with University of Chicago Hospitals. "If [patients] aren't restricted to our network of specialists, how do we control costs under capitation?"

According to United HealthCare, the department's action doesn't preclude HMOs from letting patients choose in-network specialists. State law now allows direct access to an Ob/Gyn without referrals or prior approvals, but the Ob/Gyn must participate in the patient's managed care plan.

ISMS supported the Ob/Gyn legislation and also supports direct access to specialists in a network if those specialists are members of the plan and have referral arrangements with patients' primary care physicians and if the patients have chronic conditions that warrant direct access. Those concepts were part of the Society's

Managed Care Patient Rights Act, which didn't advance during the General Assembly's spring legislative session.

It's out-of-network access to specialists that creates problems for entities like HMOs, whose capitated contracts are based on a set fee per member per month. Such contracts are manageable only if network physicians can track costs and control the delivery of services, which is possible only if referrals are kept within the network.

"It's everyone's desire to see people have the doctor of their choice, but once they choose a primary care physician, they can't just go to any specialist when-

ever they decide they want to. That's not managed care," said Vivoda.

Evan Freund, a partner with Health Services Initiatives, a consulting firm in Chicago, said open access has "major ramifications for providers. Many are at risk for all the care provided, but they can't control that use if patients go out of network. It makes you wonder what [HMOs] mean by managed care."

An official of another IPA, who requested anonymity, said, "The problem will arise when good doctors can't afford to take the capitation payment." HMOs are cutting their premiums, but if patients go off network, that will cut further into capitated payments, he added.

The official noted, "What will solve this will likely be buying groups such as employers contracting directly with physicians through MSOs to ensure that patients can get high-quality care without the HMO middleman."

Consumer demand, not a profit motive, led United HealthCare to open up patient choice, said Kaveh Safavi, MD, Chicago-based medical director for the health plan. "Some IPAs pre-spend their [capitation] dollars by guaranteeing specialists a set amount of work. Then, if someone goes outside their network, that's an added cost for them," he said. "The solution is not to pre-spend, but to base fees on utilization."

"If you are a typical fragmented IPA, limit the amount of risk you take under managed care, at least until you can put together a more integrated health care delivery system," said consultant Gloria Mayer, the former chief operating officer of Friendly Hills Healthcare Network in La Habra, Calif., a large regional medical group in Southern California.

Dr. Safavi added that the breadth of specialists in a network is the key to surviving under expanded patient choice. "If your specialty group numbers in the many hundreds, almost nobody is going to need to go outside."

An industry analyst noted, however, that if given the opportunity, some patients will go out of network whether they need to or not.

Mayer said that another critical component is having medical stop-loss insurance, a product that protects physicians when medical expenses exceed capitated payments and that is available through ISMIE. Physicians must seek out such products to succeed in the changing world of managed care, she said. ■



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REPORT for Illinois Physicians

MEDICAL POLICY DEVELOPMENT

Health Care Service Corporation (Blue Cross Blue Shield of Illinois - BCBSI) maintains a medical policy manual that consists of a collection of statements which reflect the current assessments of the status of existing, as well as, emerging medical technology. Previous "Reports", 9-27-96, and 10-25-96, have provided you with information concerning medical policy development and utilization.

This report provides an update on BCBSI's medical policy development process. Following identification of a need for a medical policy, BCBSI physicians will develop proposed policies. Prior to final adoption each new or revised policy will be submitted to practicing Illinois physicians, complete with relevant literature, for advice and comment.

The reviewing physicians will be those physicians currently serving on our eight Subspecialty Clinical Advisory Committees or those physicians, representing 26 subspecialty areas, who have previously agreed to serve on our BCBSI Consultants Panel. Each reviewing physician will receive a copy of the proposed policy that would impact on his or her specialty. Generalist physicians will also be included in the process whenever appropriate. A cover letter which will briefly highlight the significant factors involved will accompany the policy. A prompt reply will be anticipated and all comments will be reviewed and considered. Policies can be amended in light of comments received.

BCBSI continues to solicit concerned Illinois physicians to serve both on its Clinical Advisory Committees, as well as, on its Consultant Panel. BCBSI compensates consultants for their contributions to its policy development process. If you are Board Certified, interested in having a voice in BCBSI Medical Policy Development and are willing to devote a portion of your time to this undertaking, BCBSI would like to hear from you. Please contact Robert F. Fucik, M.D., Medical Director for Medical Policy and Medical Adjudication, at (312) 653-7924.

Correction

In the story "Physicians testify about problems with access, emergency care" (Sept. 12 issue), Bruce Douglas was incorrectly identified as an MD.

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Medicare right-to-contract law not what the doctors ordered

CHANGES: Final-hour rewrite of Balanced Budget Act provision renders amendment 'useless.' BY LINDA MAE CARLSTONE

[WASHINGTON] Included in the Medicare reforms in the Balanced Budget Act of 1997 is permission for physicians and Medicare patients to enter private contracts, but the surprise strings attached are causing some right-to-contract proponents to battle for revisions.

The new provision lets a patient and a physician enter a contract whereby each side agrees not to bill Medicare for the doctor's services. Patients under contract must pay fees to the physician through their own means, without using Medicare reimbursement. Physicians are cut loose from Medicare regulations, including fee limits, for patients under contract.

At a glance, the law appears in step with ISMS' position that patients should be able to contract with physicians for medical care without being penalized.

But the private-contract terms signed into law Aug. 5 by President Clinton are unworkable for most physicians. That's because final-hour language inserted into the bill stipulates that physicians entering private agreements must forgo all Medicare reimbursements from all patients for two years after the starting date of the contract.

"It's almost useless," said William Kobler, MD, a member of ISMS' Third Party Payment Processes Committee, describing the impact of the provision. "It's a mystery why they even bothered to pass it. It does not solve physicians' need to selectively contract with patients who have the ability and desire [to pay on their own] and still be able to bill Medicare for other patients."

PATIENTS, TOO, would have little use for such an arrangement, according to Kathie Wood, senior analyst/Medicare B provider education, at Health Care Services Inc., the Illinois Medicare carrier. "They would be paying for insurance they can't use. Doctors dealing with wealthy patients would be the only ones to use it."

The new provision has its roots in a right-to-contract amendment – minus the two-year blackout – sponsored by U.S. Sen. Jon Kyl (R-Ariz.) and supported by the AMA. Unbeknownst to supporters, revisions inserted in conference committee added the two-year Medicare opt-out to the final legislation, said AMA President Percy Wootton, MD. The new version was likely submitted to avert a presidential veto, he said.

As passed, the law guts the intention of the original Kyl amendment, which was to let physicians selectively contract with patients who have the desire and ability, and to still be able to bill Medicare for service to other patients, according to the AMA.

"The whole object was to give patients and physicians a choice, and right now that's not possible," Dr. Wootton said. "The way it passed, no physician would take that choice of opting out of Medicare for one patient and not being able to see other Medicare patients."

Kyl reacted swiftly, introducing on Sept. 18 new legislation to restore the amendment's original language. The new wording replaces the section that prohibits physicians from filing for Medicare

reimbursement for two years after entering a private contract. The proposal will be submitted as a technical correction, allowing it to sidestep the committee process. The AMA is pressing for the correction to be passed before Congress adjourns this year, Dr. Wootton said.

The Kyl amendment will open up

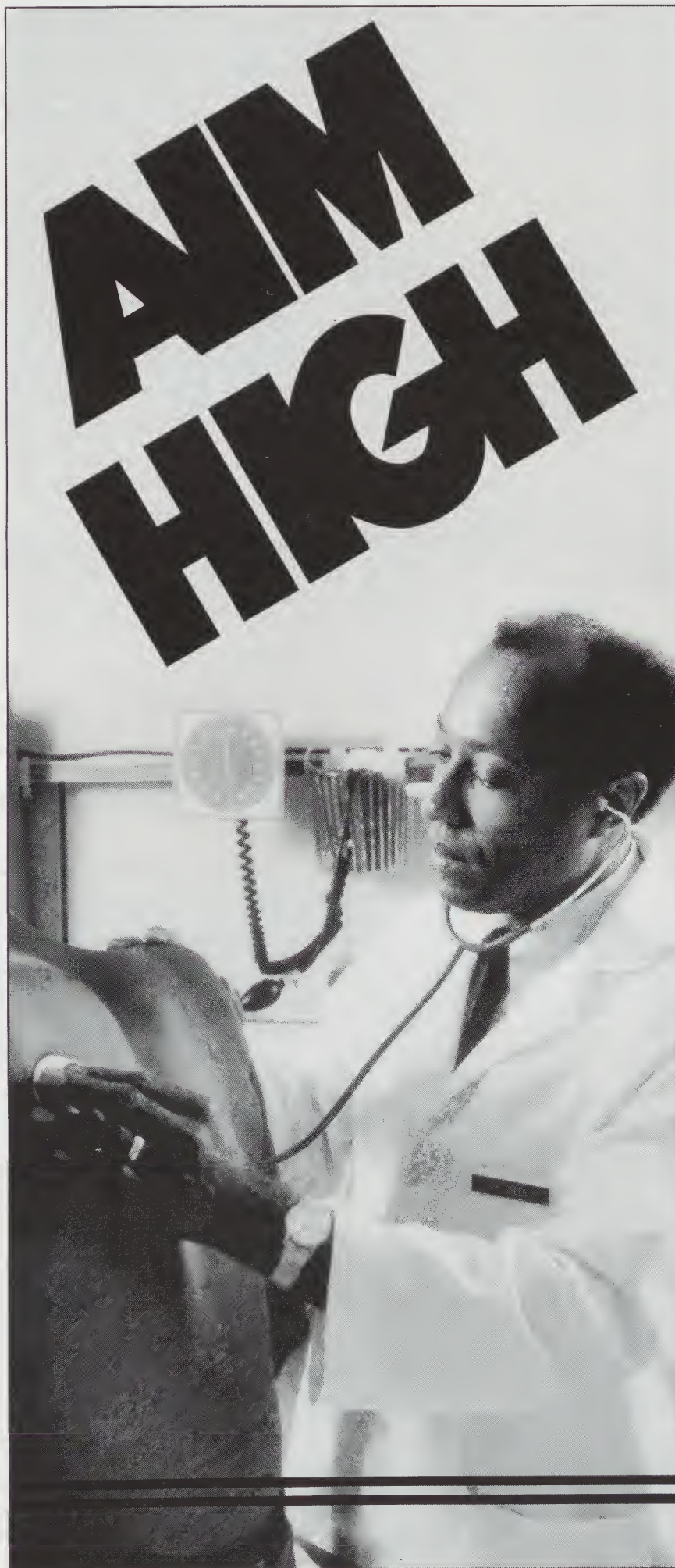
access to some specialists who otherwise would not serve Medicare patients, according to an AMA spokesperson. He cited the example of a renowned surgeon whose private fee is three times what Medicare pays. The doctor is willing to accept Medicare limiting fees for low-income patients if that wouldn't preclude him from charging higher rates to patients who can afford them, he said. Case-by-case contracts would allow the doctor to do that.

The law specifies that doctors must submit an affidavit to the federal government within 10 days of entering a private contract. The affidavit must state that the

physician will not submit any claim for any item or service for any Medicare beneficiary during the two-year period beginning on the date the affidavit is signed.

Wood advised doctors to keep a copy of the affidavit, as should be done with any Medicare document. The Illinois carrier hasn't yet received any official instructions on this from the U.S. Health Care Financing Administration, she said.

The law also states that contracts must be in writing and signed by the patient before services are delivered and that contracts cannot be entered by patients facing emergency or urgent health care problems. ■



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EDITORIAL

Diet pills cause feeding frenzy

Fenfluramine and dexfenfluramine suppress appetite, but their withdrawal from the market Sept. 15 by the Food and Drug Administration has created a feeding frenzy among some plaintiff attorneys. In fact, ads trolling for plaintiffs have appeared in national newspapers. Class-action lawsuits had been filed or were pending in more than 10 states as this issue went to press.

The dangers of the combination of fenfluramine and phentermine, or fen-phen, were publicized in July when physicians at the Mayo Clinic released the results of a study linking use with valvular heart disease. The study, published in August in the New England Journal of Medicine, reported on 24 women, each of whom showed unusual valvular morphology and regurgitation. Eight of the women had newly documented pulmonary hypertension.

After the Mayo study, the FDA reviewed records of 291 patients who had taken the drugs and found that 92 had problems with their aortic valves.

How did this happen and how can we prevent it from happening again? The answers are complex. This situation was at least partly driven by Americans' quest for slimness and pill-popping solutions instead of behavioral ones. A physician at George Washington University said he is aware of a patient who knows of the drugs' risks but is still hoarding leftover pills from her friends.

The FDA has been criticized for

approving dexfenfluramine in 1996, when only a year later the drug had to be pulled. Although the panel that approved the drug didn't know of any potential cardiac valve problems, the members were concerned because no long-term studies had been done. But they believed that approval was justified by the health problems related to increasing obesity, and they approved the drug for short-term use for clinically obese, not just overweight, patients.

What might have been a smaller-scale problem has flourished because of the number of Americans taking either fen-phen or dexfenfluramine. The drug manufacturers, which market directly to consumers, and the media help create a demand for such products, and patients often respond by flocking to their physicians to ask for publicized drugs – even if they're off-label.

In 1992, 31 percent of antibiotics prescribed in the United States were for colds, upper respiratory tract infections and bronchitis, even though 90 percent of the infections were viral, according to JAMA. Again, some patients want medication for every malady, even if that medication is ineffectual and overuse contributes to the proliferation of antibiotic-resistant bacteria.

In USA Today, physicians advised their colleagues to fully explain to patients the risks involved with every drug. And if a patient doesn't meet the criteria for a drug, just say no.

PRESIDENT'S LETTER

In finalizing tobacco settlement, kids must come first

Jane L. Jackman, MD



When children recognize Joe Camel more readily than Mickey Mouse, we know we have a public health disaster pending.

When the \$368.5 billion tobacco deal was announced this year, it was hailed as the most significant step in the war against tobacco since the surgeon general's report on the health risks of smoking. Visions of "the Marlboro man riding the back of Joe Camel into the sunset" cheered doctors, who see firsthand the havoc that tobacco wreaks on health.

When the settlement was announced, the tobacco companies seemed happy to have a limit on their legal liability after having been sued by 39 states and facing more than a dozen class-action lawsuits. In fact, the value of tobacco stock on Wall Street actually increased following the announcement! States that sought compensation for the costs of treating Medicaid recipients for tobacco-related illness were happy because of the prospect of quick payment. Some public health groups were initially pleased because of the increased taxes on tobacco, the restrictions on advertising and the measures to decrease underage smoking.

However, the settlement is having a hard time passing Congress. President Clinton and some anti-smoking legislators want to toughen the settlement, while those legislators who generally favor tobacco companies seem reluctant to step forward and risk repercussions at the polls.

The AMA and other public health advocacy groups also want to toughen the final deal. In particular, the AMA wants the Food and Drug Administration to have stronger authority over nicotine as an addictive drug. Equally important, doctors want realistic targets for reducing underage smoking with adequate fines against tobacco companies if the goals are not met.

I agree with Dr. David Kessler and the FDA that smoking is a "pediatric disease." In 1993, 46 million Americans, 22.4 percent of the U.S. population, were smokers. In the same year, 30.5 percent of high school students reported smoking within the last month, and

11.5 percent said they used smokeless tobacco. Contrary to tobacco company protestations that Joe Camel advertisements do not entice children, several studies published in JAMA point out how seductive Madison Avenue can be to impressionable teens and children. When children recognize Joe Camel more readily than Mickey Mouse, we know we have a public health disaster pending.

President Clinton is the first seated president to take on tobacco companies with such zeal. He had his priorities straight when he said that kids must come first. The issue, he said, "is not about how much money we can extract from the tobacco industry. It is about fulfilling our duties as parents and responsible adults to protect our children." As doctors, we should be concerned with fulfilling our duties as health educators and public health advocates.

In 1987, the AMA announced its goal of a "tobacco-free society" by the year 2000. Despite our efforts to educate children, we are still a long way from achieving this objective. My own son will be a graduate of the "Class of 2000" in just under three years. I wish I could say his class is "smoke free." I realize how far we have to go when I drive by the Burger King parking lot and see teens hanging out and lighting up. I agree with our president that the settlement's penalties for missing the targets to reduce youth smoking are a joke. He proposes hiking cigarette taxes up to \$1.50 a pack, which could cost the industry \$30 billion a year in lost sales. This, along with FDA regulation, would help us with our goal of a tobacco-free society by 2000.

The outcome of the settlement remains to be seen. If the tobacco companies are pushed too hard, the deal may fold. Although we should push for the toughest penalties possible, if the deal folds, it will mean lengthy lawsuits and more children who take their first puff of a cigarette. In finalizing this settlement, kids must come first.

GUEST EDITORIAL

A big fat target

By Mark F. Bernstein

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Now that Big Tobacco has been humbled by its \$11.3 billion settlement with the state of Florida, it seems a good time to move on to the Next Big Thing. By that, I mean the next big public health crusade, the next thing everyone used to wrestle with (or perhaps even enjoy) in peace until we decided it was all part of a sinister plot. I propose food.

Happy Meals? Kid, how happy do you think you're going to be when you get your cholesterol test back in 40 years?



Not any food, of course. I mean the artery-clogging, waistline-expanding junk food we all love. This is serious business, as grave a threat to the public health as tobacco ever was. According to the American Heart Association, obesity causes more than 300,000 deaths each year from heart attacks and strokes, not to mention innumerable bypass surgeries, liposuctions and joint replacements. This being America, of course, ordering Biggie Fries instead of the salad bar can't possibly be our own fault. It is a sad fact of modern life that although we claim to prize individual choice above all else, nothing bad that happens is ever done of an individual's own free will. And in a nation where people really believe they can lose weight by drinking two diet milkshakes a day, credulousness is not a problem.

The solution? Sue 'em all: Nabisco, McDonald's, Land O' Lakes, Hershey's, Ben & Jerry's, Domino's. The whole bunch. One big national legal jihad against the angioplasty merchants. A Croissan'wich class action. Any hotshot state attorney general with an eye on the governor's mansion would be hard-pressed to pass that up.

If all this sounds a bit preposterous, it only means you have an underdeveloped sense of victimhood. The parallels between Big Tobacco and Big Fat are too striking to be overlooked. Both sell products that are enjoyed by millions but that have barely concealed health risks. Both rely on celebrity endorsements: Once it was Babe Ruth pitching Chesterfields, now it's Shaquille O'Neal pushing Taco Bell. Both have derogatory nicknames: coffin nails and junk food. And as Americans become more health-conscious, both seek to expand overseas markets.

Those Golden Arches in Red Square only look innocuous.

In another eerie parallel with cigarettes, makers of junk food often increase levels of artery-clogging fat to further the addiction (witness Double Stuff Oreos), sometimes going so far as to infuse secret additives (perhaps Rep. Henry Waxman (D-Calif.) can find out what exactly is in the Big Mac's special sauce). Despite chocolate's known addictive properties, bakers have conspired for years to break it into small, hard-to-detect pieces called "chips" before hiding it in cookies. And as anyone knows who

has ever been unable to resist snarfing a friend's M&Ms, the risk of secondary exposure is undeniable.

Then there is the relentless pandering to children. Junk-food companies, even more so than tobacco companies, rely on colorful cartoon characters to sell their products. Sometimes these characters carry the romantic brand of the outlaw (the Hamburglar) or even respectable authority (Mayor McCheese). Joe Camel has been stuffed and mounted in the den of public opinion; why not turn on the Keebler Elves? Children are further enticed with toys and tie-ins to Disney movies, hooked on habits that will turn their cardiovascular systems to granite in later life. Happy Meals? Kid, how happy do you think you're going to be when you get your cholesterol test back in 40 years?

It's just a matter of time before the Wisconsin Cheese Lords are hauled in by a Senate committee or before the FDA

decides to regulate butter as a drug. Just imagine the grilling some poor Doritos executive will have to endure in the future. Did I say grilling? Try deep-fat frying. Bill Clinton thinks he feels our pain? He is a poster boy for our pain. And surely Al Gore must have lost some relatives to food ills somewhere.

Best of all, though, going to court would relieve us of the imperative to do something ourselves about that spare tire. Litigation satisfies our craving for a public scapegoat and is potentially much more lucrative, besides. The Cinnabon settlement alone ought to be enough for us all to retire on.

It is too hot to exercise. Dieting demands willpower, and why bother if you're just a victim?

Come on, America. Get off that couch and sue.

Bernstein is a writer in Philadelphia.



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ISMIE Update

Physicians can finesse their stress

SEMINAR: Effective stress management can give doctors peace of mind and help reduce their liability.

BY MINDY S. KOLOF

[CHICAGO] Physicians have good reason to be stressed these days with mounting pressures in the practice of medicine. But some physicians have found ways to cope. A poll of doctors with low levels of stress showed that they practice the four Cs: commitment to their patients and work, a feeling of challenge, control over their life and connection with friends, family and colleagues, said Debra Klamen, MD, who presented a stress management workshop sponsored by ISMS' Physician Assistance Committee on Sept. 10 in Chicago.

It's particularly important for physicians to learn to manage their stress, Dr. Klamen said. "A recent study showed that malpractice rates dropped dramatically after hospital staff took stress management workshops, so it's beneficial for you and your patients."

Dr. Klamen and seminar attendees listed common stressors for physicians — heightened patient expectations, managed care constraints and the need to practice defensive medicine. Stress signals include flu-like symptoms and gastrointestinal distress, excessive emotions like anger or irritability, forgetfulness and substance abuse.

Depression and a lack of empathy can accompany stress-handling problems and can lead to even more problems, she



Dr. Klamen

explained. "Fifty-three percent of interns showed signs of clinical depression in their first year," Dr. Klamen said. Diminished empathy can lead to poor physician-patient communication, and "the No. 1 reason a patient sues is bad communication with the physician."

"If you feel stress levels rising, you know you must do something about it," Dr. Klamen said. Not all reactions to stress are healthy, though. Denial is common, she said. "When asked how many hours they could stay awake without impairing their function, a large number of doctors said 60 — clearly an impossibility." Physicians may also experience cognitive dissonance, Dr. Klamen explained. "Some residents

have actually told me that the only problem with being on call every other night is you miss half the good cases!"

Relatively few doctors practice even simple techniques for taking care of themselves, Dr. Klamen said. Only 5 percent of interns and residents eat lunch, compared with 80 percent of the general population. Just 2 percent of interns and residents and 5 percent of attending physicians exercise regularly, vs. 45 percent of nonphysicians. And a scant 1 percent of interns and residents get enough sleep, compared with 60 percent of nonphysicians.

Attendees learned simple relaxation techniques, including breath meditation, progressive muscle relaxation and guided

imagery, through which the individual imagines descending flights of stairs, for example, to reach a place of relaxation.

Dr. Klamen emphasized the role of friendship in creating balance, citing statistics from the California Department of Mental Health. "People who isolate themselves from others have two to three times the risk of premature death. Pregnant women under stress and without supportive relations have three times more complications than pregnant women with close ties who are equally stressed. The rates of mental hospitalization are five to 10 times greater for separated, divorced or widowed persons than for married people."

The group was also taught to use a "personal power matrix," a way to consider options in any situation. If a circumstance can be controlled, taking action gives mastery of the situation, while not acting is tantamount to giving up. But for situations that can't be controlled, opting for action results in ceaseless striving, and nonaction means letting go. "Most physicians go back and forth between situation mastery and ceaseless striving, which is very stressful. We need to let it go if we can't control it," Dr. Klamen said.

Enhancing interpersonal skills is one way to better deal with confrontations. Although physician training promotes passive-aggressive communication, "assertive behavior is a better alternative," Dr. Klamen said. For instance, if an intern is constantly late for rounds, you can challenge him aggressively by saying, "You're such a jerk, holding us up. I want you here on time from now on." Or you can use an assertive approach: "I don't like it when you're late for rounds; it makes us all late. Please be here on time." The first method generates negative emotion, blame and demands, but the second expresses feelings, the effects of the person's

Are you burned out?

This quiz should help you find out whether you're on the road to burnout or you've already arrived.

- ✓ Do you feel generally more fatigued and less energetic?
- ✓ Do you feel less of a sense of satisfaction about your performance?
- ✓ Are you working harder but accomplishing less?
- ✓ Do you feel more cynical and disenchanted with your work and the people at work?
- ✓ Are you getting more irritable, angry and short-tempered with people around you?
- ✓ Are you seeing close friends and family members less often?
- ✓ Are you having more than your share of physical complaints like aches, pains, headaches, colds or the flu?
- ✓ Do you feel that you just don't have anything more to give to people?

If you answered yes to more than two questions, you're in the early stages of burnout, and if you answered yes to more than six, you have full-blown burnout, according to Dr. Klamen.

actions and a polite request for change. "It focuses on the behavior, not the person," she said.

Dr. Klamen also suggested ways to deal effectively with aggressors. The broken record technique involves repeating a statement in a calm, modulated voice. Derailing is raising a subject that's unrelated to the situation. Or, just taking a time out can be helpful.

Ending on a positive note, Dr. Klamen said, "If you start to incorporate any one of these things into your life, you'll dramatically reduce your stress levels." ■

MALPRACTICE ROUNDUP

Physician not liable for patient's addiction

A California superior court ruled that a physician did not cause a patient to become addicted to painkillers.

In *Biss vs. Bohr*, an orthopedic surgeon prescribed large doses of hydrocodone bitartrate and Damasone-P after the patient's arthroscopic surgery, according to the July edition of *Medical Malpractice Law & Strat-*

egy. The patient told the court that she subsequently became addicted and was hospitalized three times for treatment of that addiction. The surgeon, however, said that the treatment with reasonable amounts of the medications was within the standard of care and that the patient's condition was closely monitored.

Exploring the Internet can be a family adventure

ISMS Alliance members hear that with a few precautions, cyberspace can be a safe place.

BY KERRI KILBY JOHNSON



David Cutler/SIS

To some, the Internet is a little like Chicago: a big and potentially dangerous place that they would rather avoid. "But the Internet is just another interesting place," said Valerie Bock, an Alliance member from Macon County who spoke at the ISMS Alliance's fall meetings Sept. 16-18 in Joliet, Bloomington and Belleville. She said that if parents use common sense, on-line exploration doesn't have to be off-limits for their children.

Mark Featherly



Bock

It's easy to understand the lure of cyberspace, said Bock, president of VCB Consulting, a Decatur-based company that works on Internet applications for schools, nonprofit organizations and corporations. Internet users can tap into the World Wide Web, where they can travel to museums like the Louvre in Paris and the Exploratorium in San Francisco.

They can also contact other users about nearly any topic imaginable through discussion forums. In addition, there's a wealth of educational information available, including Web pages designed by teachers, medical information sites and research papers on thousands of topics.

Youngsters can also use e-mail to correspond with relatives and friends in faraway places, and some families even design and post their own Web pages to keep their friends and family up to date.

The first step in keeping the Internet safe for children is determining who should be the family's guide, Bock said. Although children are often more technologically proficient than their parents, they may not be cautious enough. Teachers know the technology, the children's course work and good sites to visit, but, of course, they have limited time to address individual interests, and they don't know family standards. That leaves parents, who are ideally suited because they know their children's preferences and the family's standards, and they want to spend time with their kids.

Parents shouldn't feel that they have to be computer savvy before they get involved. "We learn to use new stuff all the time because we think it's going to be useful," Bock said. "It's worth getting over the fear of technology because the benefits are so enormous."

Bock discussed some of the threats on the Internet: exposure to dangerous people and dangerous ideas and the possibility of being "sucked into absorbing, alternative worlds." These are manageable threats, she said. In addition to the Internet, there are many sources of dangerous ideas — books, television, movies, newspapers and video games. As long as parents explore the Internet with their kids to help them make sense of what they see, kids should be fine. And excursions into unacceptable territory can be ended if necessary, just as parents turn off an unacceptable television program, for example. "I exercise the same control over what happens on the Web," Bock said.

AS CHILDREN BECOME teen-agers, they may want to use the Internet more independently, making it more difficult to know what they're viewing on the Web. One solution is to place the computer in a common area of the house where a teen-ager is less likely to visit off-limits sites.

Dangerous people can be found not only on the Internet, but also at school, on city streets and country lanes, and even in children's own families, Bock said. Youngsters need to be trained to check with an adult when they're uncomfortable with someone they meet on the Internet.

It's true that children may get "sucked into" an alternative world on the Internet, Bock said, but they also can become too absorbed by video games, books, friends or hobbies. Parents need to set limits on computer time, just as they do for television and video games.

The best advice is for families to share the Internet experience, maintain awareness of appropriate use and limits, and keep an open dialogue going, Bock said. After family rules have been developed and shared, everyone can relax a bit and enjoy the trip. ■

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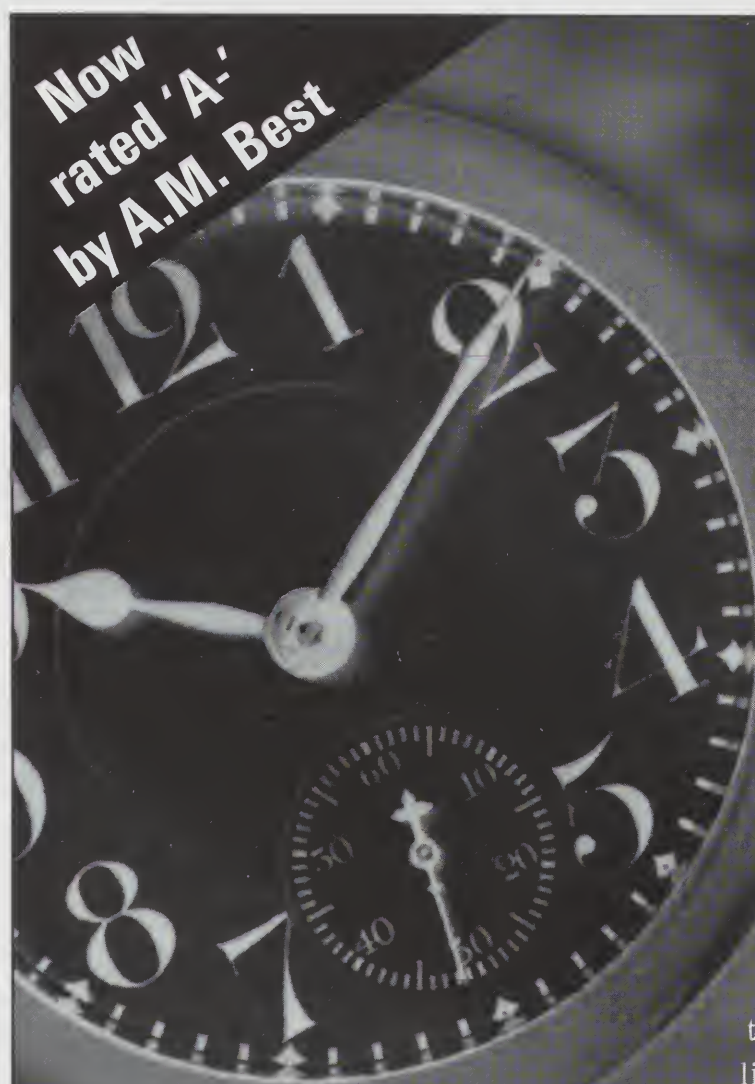
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Rockford physicians

(Continued from page 1)

30 percent of about 150 nonmanagement physicians who are employed at the clinic. If the election is held, a majority of voters must support collective bargaining to legally bind the RHS to negotiate with the council.

As Illinois Medicine went to press, about 75 physicians had signed a statement of principles (see "What's behind the council") to indicate interest in forming the collective bargaining unit, Dr. Kaplan said. If it wins the election, the council plans to negotiate with manage-

ment for improvements in patient care and professional practices. If negotiations reached an impasse, said organizers, the unit would not strike but could take other action to try to break a stalemate.

As the council picked up steam last month, the corporation appeared to make concessions to win support, according to Dr. Kaplan. At a meeting held Sept. 23, administrators presented a proposal to revamp the administrative structure by giving physicians a much stronger say in decision-making.

RHS administration called the plan for change the next step in a long-range charge from hospital Chief Executive

Thomas DeFauw, MD. That charge asked physician leadership to recommend ways to empower physicians and to react to the possibility of naming a physician as CEO and medical director of the organization.

But Dr. Kaplan said the proposals to increase physicians' power were the administration's attempt to neutralize the physician group. "It's a clear indication our organization is making an impact."

The offer did little to slow the council, which responded by pushing forward toward organization. "Our fear was that two years down the road — with no group to represent the physicians —

[administrators] could go back to their old ways," Dr. Kaplan said. Currently, nothing is in writing, and some concerns have not been fully answered, he said. Council members have raised such budget concerns as length of hospital stay, which they believe reveal "the writing on the wall," Dr. Kaplan said.

Last year RHS cut staff by 400 employees through layoffs and attrition. "The current staffing at the clinic and hospital is at a level that could impact our ability to deliver the care we feel appropriate," Dr. Kaplan said.

Dr. McCanse said financial factors have dictated the need for changes "in response to the marketplace. All health systems are looking at ways to become cost-effective."

Dr. McCanse conceded that action to empower physicians has not happened fast enough. "I am frustrated too," he said. The administration will lay its proposals before clinic physicians at a series of meetings to solicit input. A tentative timetable calls for recommendations to be submitted by Oct. 17 to Dr. DeFauw and presented to the board of directors at its Oct. 23 meeting.

The Rockford physicians' movement to organize is actively supported by the AMA, which has retained the services of two labor law attorneys to work on the case, according to Ed Hirshfeld, AMA vice president, health law. It is also supported by the local medical society.

The AMA favors collective bargaining and the use of the National Labor Relations Act as a tool to protect the right of physicians to organize and negotiate with their employers, he said. "Our objective is to give physicians a meaningful voice."

In a published report on physicians and unions, the AMA stated that between 14,000 and 20,000 physicians have enrolled in unions. Part of the reason for interest in organizing is that physicians feel increasingly powerless to respond to the leverage exerted by health plans, according to the report. Just this year, the AMA established a division that is responsible for aggressively representing physicians who are frustrated over encroachment on their clinical decision-making.

But the AMA balks at physician participation in traditional trade unionism, Hirshfeld said. "We are not in favor of physicians going on strike or withholding patient care to gain leverage in collective bargaining." ■

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What's behind the council

The Rockford Physicians' Council describes itself as a democratic and self-governed organization designed to negotiate solutions to problems such as the failure to involve practicing physicians in key decision-making that affects patients' well-being.

In its statement of principles, the council says that it has organized to do the following:

- ◆ Operate as a democratic and self-governed organization of staff physicians
- ◆ Restore the integrity of the physician-patient relationship and the role of the physician as patient advocate
- ◆ Organize an equitable system of due process
- ◆ Develop a means of negotiating fairly

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ICIANS SHOULD COVER THEMSELVES (PAGE 6)

Turning the
residency
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process inside out

PAGE 7

Illinois Medicine

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Mandatory
report responses
now required

PAGE 2

Medical education programs face effects of federal belt-tightening

IMPACT: GME programs begin reducing their residency slots. BY JANE ZENTMYER

[CHICAGO] Even though Congress and President Bill Clinton didn't make their budget decisions by July 1, Rush-Presbyterian-St. Luke's Medical Center did. Anticipating a freeze or reduction in federal funding for residency training, Rush trimmed \$2.4 million from its graduate medical education budget, according to Janis Orlowski, MD, executive dean of operations for the medical center.

"Guess what? It was not enough," Dr. Orlowski said. "On Aug. 5, Congress [and the president] made their decision and affected graduate medical education programs across the country. There were some academic medical centers that went from a positive to a negative balance on that day. This is a dramatic, one-day effect on academic medical centers." Rush now faces a \$15 million cut in its funding during the next two years.

The effect of the federal balanced budget act on medical education funding was one of the subjects discussed at the "Medical Education and its Future" forum held Sept. 10 by the Institute of Medicine of Chicago, a nonprofit organization that promotes the study and advancement of medicine and allied sciences.

Panelists also discussed the country's oversupply of physicians. At the end of 1995, there were 720,000 physicians in the United States, and another 170,000 medical students and residents were preparing to enter the workforce, said Michael Scotti Jr., MD, AMA



Dr. Orlowski

vice president for medical education. In 1960, the physician-to-patient ratio was 1:703 people, and 35 years later, it's 1:365, according to the AMA.

Common sense has led some GME programs to begin reducing their numbers, Dr. Scotti said. A 1996-97 AMA survey showed that nearly all specialties that had difficulty placing graduates for two consecutive years reported at least 10 percent fewer first-year residents than in 1994, as reported in JAMA. These reductions were made before any cut in federal funding, and most can be traced to reduced numbers of international medical graduates, Dr. Scotti said.

"By any criteria we now have too many physicians or soon we will have," Dr. Scotti said. "We have no national health policy

that helps to decide what the average number should be or what the specialty mix should be." Exactly how much of a reduction is needed remains to be seen, but "you have to get to a 2 percent reduction before you get to 10 percent."

The number of physicians will be reduced even more because of federal funding cuts. Medical centers receive an average \$100,000 in federal funding per resident, Dr. Scotti said. But the new budget act offers hospitals financial incentives not to train residents.

Slashing medical education funding may quickly reduce the number of physicians, but cutting too much too fast can have
(Continued on page 11)

Physicians file labor complaint

BY LINDA MAE CARLSTONE

A group of Rockford physicians working to form a collective bargaining unit has filed a complaint with the National Labor Relations Board charging their employer interfered with their efforts to organize. The complaint, filed Oct. 9, charges that the Rockford Memorial Health Services Corp. has taken actions to discourage the Rockford Physicians' Council from proceeding with its legal right to form a bargaining unit.

The council was formed in July by a group of Rockford Clinic physicians who seek increased physician involvement in administrative decision-making. Rockford Clinic is owned by Rockford Memorial Health Services

Corp., which is a subsidiary of Rockford Health System.

Specifically, the three-part complaint alleges that the corporation threatened changes in working conditions and dismissal if they participate in organizational activity. According to the complaint, this charge stemmed from a meeting at which an administration representative told 20 employees they would be terminated from their positions as representatives of various departments for participating in the organizational effort. Several of the employees are not supervisors, which means the incident violated the National Labor Relations Act, the complaint said.

The complaint also states that the administration threat-

(Continued on page 3)

LATE
NEWS

Federal funds could help insure low-income Illinois kids

ACCESS: State is working on implementation plan. BY JANE ZENTMYER

[CHICAGO] A new initiative could give Illinois federal funds for a children's health insurance program designed to cover an estimated 113,000 uninsured youngsters. This year's federal Balanced Budget Act earmarks \$20.3 billion for fiscal years 1998 to 2002 to be distributed among the 50 states so they can implement children's health insurance programs. Illinois' share of the \$4.3 billion set aside for 1998, \$122.5 million, became available Oct. 1, the start of the federal fiscal year.

Although Illinois has access to the federal money now, state officials still need to decide to participate. If they do elect to proceed, they must develop a plan to provide children's health insurance and get approval for it from the U.S. Department of Health and Human Services. On Sept. 11, state officials met with children's advocates at a forum on implementing the program in Illinois. The Health and Medicine Policy Research Group organized the forum, which was held in Chicago.



CHILD HEALTH FORUM PANELISTS Arthur Kohrman, MD, and U.S. Department of Health and Human Services Regional Director Hannah Rosenthal examine a brochure.

"We're going to have to make some hard choices hopefully relatively quickly - very difficult choices - and a willingness to listen doesn't necessarily

mean a willingness to agree," said A. George Hovanec, administrator of the Illinois Department of Public Aid's division.
(Continued on page 11)

INSIDE

What it takes
to legally
deactivate an
airbag

PAGE 3

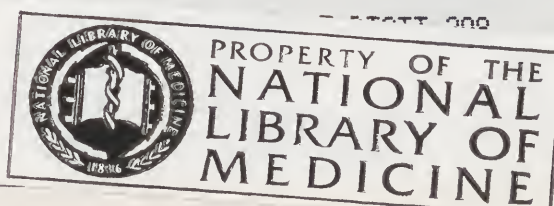
DEPARTMENTS

Malpractice
Roundup.....6

Classifieds9

Correction

In the story "Rockford physicians form collective bargaining council" (Oct. 10 issue), Thomas DeFauw, chief executive of the Rockford Health System, was incorrectly identified as an MD. We regret the error.



Illinois physicians must respond in writing to mandatory reports

MEDICAL PRACTICE ACT: Without a physician's letter, IDPR can pursue disciplinary actions. BY JANE ZENTMYER

[CHICAGO] Illinois physicians should keep in mind a change to the Medical Practice Act that became effective July 1. Previously, physicians had the option of responding to the receipt of mandatory reports by the Illinois Department of Professional Regulation, but now physicians are required to provide a written response or face disciplinary action.

"We're just now starting to get the first batch of the mandatory report complaints that fall under the new act," said Andrew Gorchynsky, MD, IDPR's chief medical coordinator. Some physicians haven't provided their written responses, and although the IDPR Medical Disciplinary Board hasn't taken any action against them yet, that time is coming, he said.

Mandatory reports are submitted by entities that are required to tell IDPR about any adverse actions taken against physicians or chiropractors. Most reports come from medical malpractice liability insurers that file reports on lawsuit judgments or settlements, Dr. Gorchynsky said. A small percentage of reports come from organizations like hospitals, he said.

Once a mandatory report has been

received, the Medical Disciplinary Board notifies the physician in a letter sent by certified mail. Physicians have 60 days from the date they were notified to send the board a written response that clarifies or explains the circumstances outlined in the report. If no response is sent, the board can use its discretion to deter-

mine whether disciplinary action should be taken, Dr. Gorchynsky said.

IDPR requested that the revised Medical Practice Act include the change in mandatory reporting because an explanation from the physician can prevent the board from wasting resources investigating a case, Dr. Gorchynsky explained. "It's always in [physicians'] best interests to respond, because the vast majority of malpractice cases settled either by settlement or judgment are not violations of the Medical Practice Act."

All mandatory reports are reviewed by either IDPR's chief medical coordina-

tor or deputy medical coordinators. The coordinators issue recommendations on the reports, which are forwarded to the board's complaint committee. The committee then reviews the coordinators' recommendations and decides whether complaints should be closed or referred to the prosecution unit for further action.

The Medical Practice Act defines 41 grounds for discipline, including gross negligence; obtaining a fee by fraud, deceit or misrepresentation; or engaging in dishonorable, unethical or unprofessional conduct that could harm the public. ■

Medical faculty urged to kick tobacco-investment habit

PUBLIC HEALTH: Teacher retirement fund supports 24 tobacco corporations. BY LINDA MAE CARLSTONE

[CHICAGO] ISMS took its anti-tobacco campaign to school recently in an effort to sway faculty stockholders in a teacher retirement fund to divest of tobacco investments.

Educators participating in the Teachers Insurance and Annuity Association/College Retirement Equities Fund will have a voice in the controversial investments through a resolution on the stockholders' proxy ballot being cast this month. The resolution calls for the board of directors to make no additional tobacco-related investments and to begin an orderly divestment of all tobacco

holdings. Ballots are being mailed this month and are due back by Nov. 10.

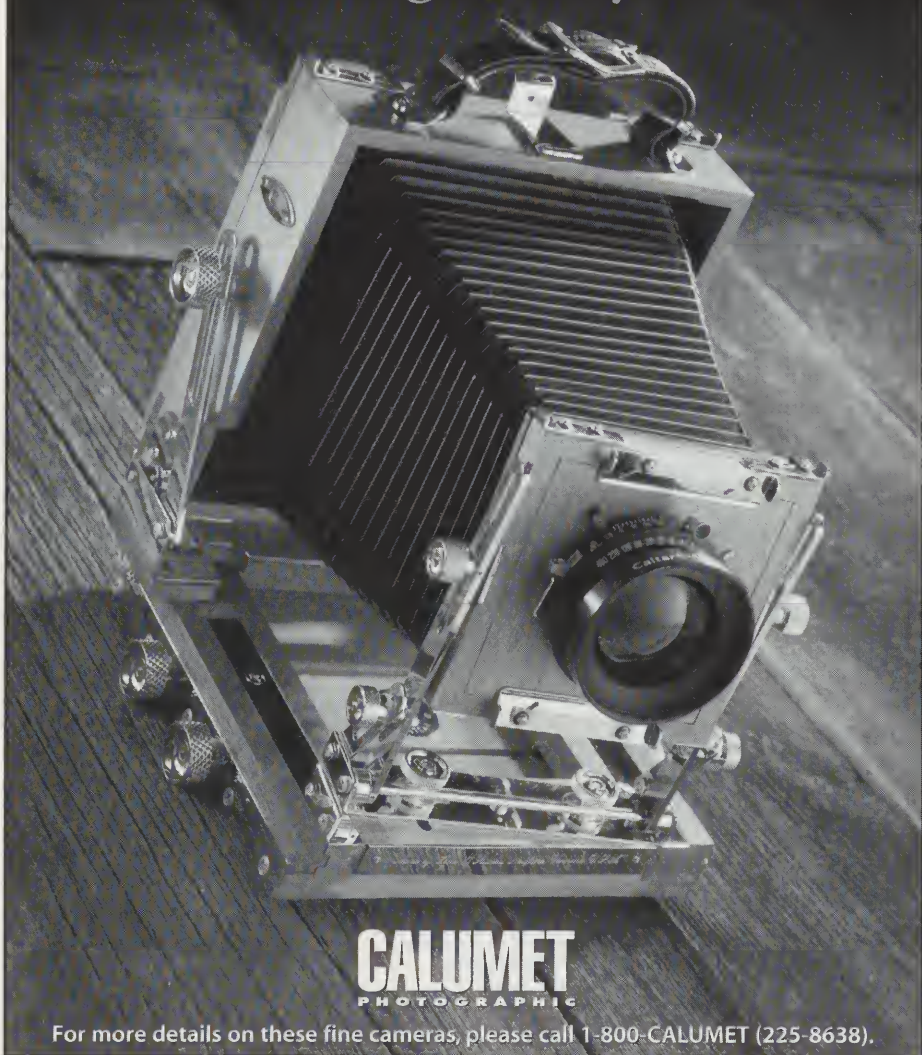
Chairman of the ISMS Board of Trustees M. Leroy Sprang, MD, asked faculty leaders at eight Illinois medical schools for help in rallying support for the ballot issue. In a letter sent earlier this month to the medical school deans, Dr. Sprang asked for support in educating faculty members about the initiative.

The CREF tobacco investment is a collegiate camouflage for the tobacco industry, said Eugene Feingold, MD, who co-sponsored the resolution with former U.S. Surgeon General C. Everett

Koop, MD. The effort to increase awareness of the ballot issue is particularly important given the low 28 percent response to last year's proxy ballot, he said. "We don't want it to get tossed out with the junk mail." Results will be announced at the Nov. 10 annual CREF meeting.

The ISMS House of Delegates adopted a resolution at its 1997 Annual Meeting that supports the divestment initiative. The position calls for ISMS members who are faculty members at medical schools to become familiar with the issue and to help inform their university colleagues about the CREF initiative. ISMS also submitted a resolution calling for similar action by the AMA House of Delegates, and the AMA reaffirmed existing policy supporting divestment. ■

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Federal approval needed to shut off airbags

LAW: A letter from a physician is not enough to authorize disconnection. BY JANE ZENTMYER

[CHICAGO] In the last three years, almost 9,000 U.S. drivers have asked the National Highway Traffic Safety Administration for permission to disconnect their cars' airbags — a move that some say could prevent the deaths of numerous young children and short adults.

While those requests often include letters from physicians outlining any medical conditions that justify disabling the airbag, the letter isn't enough for a mechanic to disable the device. ISMS General Counsel Saul Morse explained, "There is a process that people have to go through. Physicians can write down the medical reason, but it's not enough for a mechanic to legally remove an airbag."

NHTSA, the division of the U.S. Department of Transportation responsible for monitoring auto safety issues,

released a proposed rule in January that would allow a switch to disconnect airbags or disable them to inflate with less force. Until the rule is put into place, NHTSA can approve deactivations for only medical reasons, said Don McNamara, the administration's regional administrator.

Shortness, however, is not considered a medical reason by the NHTSA. But a

child who must be in the front seat of a car for continual medical care could justify disconnecting an airbag, McNamara said, as could a short driver who had recent open-heart surgery. "Generally, we grant requests if there is some medical condition, but we're not granting those who say, 'I want my airbag disconnected because I don't want it,'" McNamara said.

Drivers who want permission to disable their airbags can write a letter to Administrator (NAO-10), NHTSA, 400 Seventh St., S.W., Washington, DC 20590. A letter from a physician isn't required to get approval, McNamara

said, but it may provide better explanations of medical conditions and elicit quicker action from NHTSA. About 7,000 requests have been granted in the last three years.

If NHTSA approves the request, the car owner will receive a letter stating the agency will not take action against a service station that deactivates the airbag. McNamara said that liability concerns have prompted many automakers to instruct their dealers not to deactivate the airbag even with NHTSA's permission.

For more information, call the DOT's auto safety hotline at (800) 424-9393. ■

Physicians file

(Continued from page 3)

ened to change the working conditions of a physician organizer of the Rockford Physicians' Council and his nurse.

In addition, the council's complaint alleges that the employer violated the law when it formed a management-employee committee to discuss and improve wages, hours and working conditions. "Essentially, the employer set up its own competing group that pre-empted the purpose of the physician council," said Jerry Clousson, a Chicago attorney representing the physician group.

These episodes began shortly after the council's steering committee started mailing information about the purposes of the council to potential members and began to hold regular meetings, said Dennis Norem, MD, one of seven physicians who formed the group's steering committee.

At Illinois Medicine press time, a spokesperson for the Rockford Memorial Health Services Corp. said the corporation had not seen the complaint and therefore had no response to the charges.

The council is working to garner employee approval to hold an election to become a certified collective bargaining agent for the physicians. For the election to be held, 30 percent of the nonmanagement physicians must approve. If the election is held, a majority of voters must support collective bargaining to legally bind the RHS to negotiate with the council. The NLRB will assign a field attorney to investigate the complaint and determine if it has merit, Clousson said. He estimated a decision would be reached in about 60 days. ■

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EDITORIAL

Treating fear of breast cancer

You might think that women who were afraid of breast cancer would be extremely motivated to do regular breast self-examinations and get regular mammographies based on their physicians' recommendations. They do think about it. In fact, the prospect of breast cancer is "always, always in the back of my mind," said a woman interviewed by the Chicago Tribune. But, perversely enough, women don't get mammograms because they're afraid of finding cancer, according to a study conducted at the Roswell Park Cancer Institute's mammography center in Buffalo, N.Y.

October is national Breast Cancer Awareness Month, so it's a good time to look at ways to ease women's fear-induced paralysis so that they can undergo regular screening and detect cancer when it's the most treatable. One way is to teach women to start doing self-exams when they're very young. Lincoln Park High School in Chicago held six workshops this month in which breast cancer survivors told teen-age girls why they should begin a monthly ritual of self-examination in their senior year of high school. In a story in the Tribune, one of the survivors admitted that she hadn't done the things she should have. "As a result, I had to lose my breast," she said.

Young women are also being sought to participate in a study at Northwestern University Medical School that will try to determine whether a low-fat diet

reduces estrogen levels in premenopausal women and helps protect them from breast cancer. Why would participants want to drink powdered soy supplements and eat twice the amount of fruits, vegetables and fiber that most Americans eat? "They're sick of losing mothers and aunts and grandmothers to cancer," said the study's co-director in an article in the Chicago Sun-Times.

The public tends to think of breast cancer as a disease affecting older women, so they're the only ones for whom mammography is useful. But a University of Chicago study found that women under 50 benefited from mammography as much as women over 50. The tumors that were detected through mammography were generally smaller and less aggressive, said the study's lead author.

To help physicians diagnose and manage breast cancer, the University of Chicago Cancer Research Center is holding a conference on Oct. 31 at the Drake Hotel in Chicago. ISMS endorses the program, which will cover such topics as patients who are being missed in screening, a review of screening guidelines, interpreting radiologists' reports and difficulties in getting older women to go for screening. For more information about the conference, doctors may call the U of C Center for Continuing Medical Education at (773) 702-1056.

The best way to fight fear is with information.

PRESIDENT'S LETTER

We must continue to focus on AIDS prevention

Jane L. Jackman, MD



If the public becomes complacent about the control of AIDS, we stand to lose the fight for HIV prevention.

First, some good news. In September we heard that in 1996, deaths from AIDS in the United States fell 26 percent from the previous year. The U.S. Centers for Disease Control and Prevention reported that the AIDS death rate fell from 15.6 per 100,000 in 1995 to 11.6 per 100,000 in 1996. Most likely this drop is due to treatment of HIV with newer drugs and the use of combination therapy earlier in the course of the disease.

From 1995 to 1996, the national birth rate dropped 4 percent among teens between 15 and 19 for the fifth consecutive year. Also, the CDC reported that fewer teens are having sex and that the use of condoms is increasing. We can be cautiously optimistic that our educational efforts at AIDS prevention are starting to bear fruit.

Also in September, however, came some bad news. In up to 50 percent of AIDS patients, the newer drugs seem to lose their effectiveness after a few months. We will now have to develop new AIDS-fighting drugs to help this drug-resistant group. Add to this the public's unfounded optimism about our ability to find a cure for AIDS and maybe we should be more concerned.

Opinion polls show that 62 percent of the public think we are "well on the way" to finding a cure for AIDS. More than half think we will have an effective vaccine within five years and that we'll find a cure within five years. As doctors, we may wish these ideas were facts, yet we know these opinions are unrealistic and probably dangerous. If the public becomes complacent about the control of AIDS, we stand to lose the fight for HIV prevention. As Daniel Zingale, executive director of the AIDS Action Council in Washington, D.C., said, "The good news does not mean that AIDS is over, and if we act like it is, it never will be."

Since we understand that AIDS is transmitted through the exchange of body fluids, we know that it should be preventable through education. However, to get people to change their behav-

iors, we need to convince them that they are vulnerable to contracting the disease. For us, this means asking patients directly about risky behaviors and advising them to reduce the risk. It's probably not too early to introduce this topic in the fifth-grade physical, as well as in health maintenance exams and family planning and obstetrical visits. Many young adults with AIDS acquired HIV when they were teen-agers, some of whom started sexual activity before their ninth-grade physical. One of the keys to reducing the number of AIDS patients is for us to communicate openly, frankly and non-judgmentally with our patients.

AIDS unfortunately is still a threat to those who engage in such risky behavior as unprotected sex and IV drug abuse. The ideal we strive for, of course, is abstinence or monogamous sex and convincing IV drug users to stop shooting up. However, there are very effective interventions that will decrease the risk, such as encouraging the use of condoms during sex and clean needles through needle exchange programs.

ISMS has an AIDS prevention outreach program for teens. Each year we send a letter to all the schools in Illinois, inviting teachers to make use of our speakers bureau on AIDS education. We always need more volunteers, and it is a wonderful way to reach out beyond our one-on-one patient counseling to large groups of teen-agers. An excellent video is available, along with a fact sheet on AIDS to guide the question-and-answer session, and a pamphlet, "Straight Talk to Teens About Sex, AIDS and Disease." This pamphlet is also available in Spanish and can be ordered for your office use.

If each of us will counsel our patients about AIDS prevention and if more of us participate in our school outreach program, we should see the AIDS death rate continue to decline, but this time because of increased prevention through education.

GUEST EDITORIAL

Refocusing on the care we give to patients

By Douglas Kaplan, MD

With the advancement of managed care, corporate interests have intruded into decisions that used to be made by physicians and their patients. Those decisions are now based on quality maps, care maps, practice protocols and utilization review. There may be some benefits to this approach, but the pendulum has swung a little too far, and it's time to bring it back and refocus on taking care of patients. That belief is why a group of physicians at the Rockford Clinic, including myself, formed the Rockford Physicians' Council, a collective bargaining unit, to negotiate with our employer, the Rockford Health System.

We are concerned about the intrusion of corporate interests into health care, the erosion of the physician-patient relationship and the push for physicians to become advocates for business instead of our patients. We also want physicians to be more involved in decisions made by administrators. Currently, the hospital's leadership chooses physicians to be part of the administration. When physicians try to address their concerns by going to these physician leaders, we are often rebuffed and find that the administration won't make decisions that we feel are needed to deliver quality health care. Just because health care administrators are MDs doesn't mean that the system represents physician and patient concerns. We want to be able to select physicians for administrative positions who have patients' interests at heart. That can best be accomplished through a democratic election, not by a hospital administration's selection process.

Other circumstances generated our interest in forming a collective bargaining unit: changes in compensation that may be an incentive in determining care, staffing cutbacks and overhauls in our practices. If doctors want something, the decision has been based on the budget rather than what is best for patients.

We're also concerned that we don't have due process for grievance procedures. Some Rockford Clinic physicians have been disciplined without the chance to refute charges against them. This has caused some doctors to fear that if they

speak out, there may be retribution. A collective bargaining unit would put in place a grievance and due process system to protect physicians who speak openly about their concerns.

Our council is a collective bargaining unit, not a union. Admittedly, the seed for our efforts may have been planted months ago when a representative of the AFL-CIO spoke with some Rockford Clinic physicians. The organized labor movement began to help protect workers from poor workplace environments, and we see our efforts as an extension of that. We are concerned about the work environment as it affects the delivery of care to our patients, and we want to protect the care that we give. But that's where the similarity ends. We are not a union, and we are not interested in striking or picketing. We want to be a collective unit that represents physicians and patients so they can voice their opinions freely in a democratic forum. We were encouraged to learn that the AMA supports the concept of collective bargaining.

Our efforts may have already been somewhat successful. Although administrators have agreed to most of our requests, they still haven't committed to allowing physicians to have democratic involvement in the process. This remains a concern, as does our fear that once we've been placated, administrators may return to their former way of operating.

If we're successful, physicians in Rockford and elsewhere may realize that collective bargaining is a way to restore physician involvement and control. In fact, I have already been called by patients and other physicians offering to support our efforts. It's time for physicians to regain control of our destiny and to influence the care we deliver. Our current system has taken that away from us.



Dr. Kaplan, a Rockford ophthalmologist, is one of seven members of the steering committee for the Rockford Physicians' Council and president of the Winnebago County Medical Society.

LETTERS

Taking the high road with expert testimony

In an otherwise helpful article, "How to be an expert witness," (Aug. 15 issue) the physician author said, "All your opinions should be based on your training and experience. If you cite books or articles, you open yourself to being questioned on those sources." He rightly says that this may embarrass the witness who does not remember the article's content and that opposing attorneys may find quotations from the work to impeach your testimony. However, there is another important issue.

The expert witness's job is to give the judge or jury the benefit of his or her best knowledge. Our best knowledge comes from systematic research published in peer-reviewed journals and scholarly overviews of such research that appear in textbooks and review articles. If we

want our courts to make decisions based on the best information, if we justifiably decry "junk science," we should support the courts' movement toward scientifically based testimony.

The Supreme Court gave this movement a major boost in the

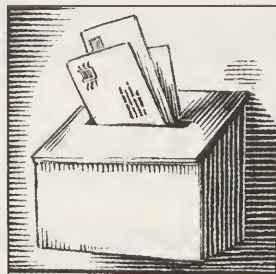
Daubert decision. The court held that novel scientific testimony must be supported by scientific data that reaches reasonable research standards. The courts are refining and working through these ideas.

Physicians who hope

that courts will increasingly make decisions based on the best available knowledge will applaud this move. Despite the discomfort it sometimes causes expert witnesses, the move to higher standards for expert testimony should be supported by all physicians.

— Robert Galatzer-Levy, MD
Chicago

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to communicate
leaves a patient
in a lurch

ISMIE Update

Nominations sought for ISMIE board membership

The Illinois State Medical Inter-Insurance Exchange will hold its Annual Meeting on April 22, 1998, at the Oak Brook Hills Resort in Oak Brook. The meeting will include an election for membership on the ISMIE Board of Governors. Board members will be elected by a majority vote of those members who attend the Annual Meeting or who vote by proxy.

The board supervises ISMIE finances and operations, and establishes all policies governing the proper transaction of ISMIE's business and affairs.

ISMIE policyholders who are interested in serving as governors should send a 150-word statement of interest and a current curriculum vitae to Harold Jensen, MD, Chairman, Board of Governors, Illinois State Medical Inter-Insurance Exchange, 20 N. Michigan Ave., Suite 700, Chicago, IL 60602.

Each candidacy must be seconded in writing by two other ISMIE policyholders. An ISMIE policyholder may second nominations for up to seven individual board candidates. All CVs and written seconds must be received at the ISMIE office on or before Dec. 31.

All candidate submissions will be reviewed by ISMIE's Nominating Committee, which will recommend a slate of nominees. Candidates who are not recommended by the Nominating Committee will be so advised and may elect to be placed on the ballot as independent candidates.

Treating patients you've never met

PANEL DISCUSSION: When filling in for a colleague, doctors need to follow procedures. BY JANICE ROSENBERG

[CHICAGO] Even though physicians are usually willing to fill in for a colleague who's away for the weekend, they should follow formal procedures when treating patients they've never met, according to risk management specialists. "Physicians like to be cooperative, but if you think what you said to a colleague will become a course of treatment, the more formal you make the situation, the safer you'll be," said Jim Stamos, an attorney with the Chicago law firm Stamos & Trucco. Stamos spoke at a panel discussion on risk management for covering physicians at St. Joseph Health Centers & Hospital in Chicago on Sept. 23.

Although physicians are well aware of their responsibilities to their own patients, they may be less certain about their obligations to patients they've never met, Stamos explained. For example, Dr. X and Dr. Y have lunch, and without mentioning names, Dr. X asks a hypothetical question related to a patient she's treating. Dr. Y responds thoughtfully but forgets the conversation by the end of lunch. But Dr. X notes Dr. Y's comments in the patient's chart and incorporates them into her treatment plan.

"The law in Illinois isn't clear about this kind of 'curbside consultation,'" Stamos said. "But the more precisely you become involved, the more likely it is that the patient has become 'yours.' It's best to learn the patient's name if you're giving concrete suggestions."

Some hospitals have specific policies about consultations and the levels of involvement for a consulting physician. Doctors should learn these policies and follow them, Stamos advised. Physicians can also protect themselves by documenting all patient contacts. They should keep logs documenting telephone interactions with their own patients, with other physicians and with hospital emergency departments.

"If you are on call for the



Roseanne Percival/SIS

emergency department, you might be called several times for one patient, and each time the ER writes your name down," explained Sharon Flint, MD, an Oak Park pediatrician who spoke at the seminar. "You give advice, but they might not follow it. In our practice, we keep a phone log where we record those phone calls and the advice we give."

Physicians should develop and follow procedures for logging phone calls. Although these procedures may seem labor intensive for doctors called at home in the middle of the night, the resulting protection from liability is worth the trouble, said Dr. Flint, who is also a member of the ISMIE Pediatric Risk Management Subcommittee. If problems

develop, any physician whose name appears in a patient's record may be named in a lawsuit. Physicians who have a log or notes detailing their involvement with the patient will be in a better position legally.

Covering or consulting physicians should also listen carefully and use good judgment whether they're communicating with colleagues or patients. For example, Dr. Y takes a call from one of Dr. X's patients who insists on Darvon to relieve her painful menstrual cramps. Dr. Y feels uncomfortable prescribing a narcotic for a patient he has never seen.

Patients may exaggerate, said Melvin Gerbie, MD, a Chicago Ob/Gyn and a member of ISMIE's Ob/Gyn Risk Management Subcommittee. "If I

don't like what I'm hearing, I don't prescribe narcotics. You'll fret more if you give a patient something that makes you uncomfortable than if you don't give it."

The patient may be unhappy, but with drugs like narcotics, the physician is safer not giving out prescriptions to unfamiliar patients. On the other hand, if an unfamiliar patient needs a refill for a chronic condition, a physician can prescribe a small number, document what was prescribed and inform the patient's own physician.

"Use your judgment," Stamos said. "Document that you got a reasonable story from the patient about what was being done for him. Check with the pharmacy to see if there's a previous prescription for the medication. If the medicine is something the patient needs to keep him alive [but you don't feel comfortable prescribing it], you may have to send him to the emergency department."

Doctors who treat other physicians' patients should also establish formal follow-up plans and procedures and adhere to them, regardless of the seriousness of the patients' condition. If the problem is serious or life-threatening, the on-call doctor should be certain that the patients' regular physicians are informed and are given the results of any tests that had been ordered. ■

MALPRACTICE ROUNDUP

Psychiatrist found negligent in repressed memory case

A federal jury in Texas ruled that a psychiatrist was negligent for failing to inform a plaintiff that alleged memories uncovered through hypnosis or other psychotherapy might not be reliable. The plaintiff was awarded \$5.9 million, according to the September issue of Medical Malpractice Law & Strategy.

In *Carl vs. Peterson*, the patient claimed that while she was being treated for depres-

sion, she became convinced that she had developed multiple personalities because she had repressed memories of involvement with a satanic cult. She claimed her therapy resulted in a divorce from her husband and the loss of custody of her children. The patient also maintained that she did not give informed consent to undergo hypnosis and that she was never told that recovered memories may or may not be true.

Turning the residency interviewing process inside out

*At ISMS' Medical Student Section seminar,
students learn what they can expect as candidates for residency.*

BY MINDY S. KOLOF

The 11th annual "Preparing for Residency Interviews Seminar" sponsored by ISMS' Medical Student Section turned the interview process inside out. Through a mock residency selection session, students became the hospital's selection committee, reviewing and ranking residents' applications.

"Putting the students in the shoes of the interviewer helps them see what motivates the questions they'll be asked," explained Michael Rainey, PhD, associate dean for student affairs at the Loyola University Chicago Stritch School of Medicine and organizer of the mock residency selection session. ISMS Medical Student Section Vice Chairman Harsh Sule served as student coordinator of the entire seminar.

Students were grouped according to specialty — internal medicine, family practice, emergency medicine or surgery. Then 11 groups of students, each led by a residency director, compiled a list of an ideal candidate's characteristics. Some were identical to attributes listed at last year's workshop — for example, academic ability, team player, enthusiasm and excellent interpersonal and communication skills. But this year's list also reflected changes in health care by including integrity, patient advocacy, clinical competence and personality.

The lists varied somewhat by specialty, with interpersonal skills being high on the most-wanted list for internal medicine. The group, led by Penny Tenzer, MD, academic director of family practice at MacNeal Hospital in Berwyn, wanted a resident who was "not arrogant but humble," and group members ranked the ability to work with others as the most important



Public speaker trainer Ann Cole of Chicago talked with medical students about how to put their best faces forward during the resident candidacy interviews.

quality. A surgery group deemed the traits "responsible/reliable/accountable" as No. 1, and a family practice group maintained that "professional integrity" was most critical.

Facilitator Keith Boyd, MD, assistant professor of internal medicine/pediatrics at Rush-Presbyterian-St. Luke's Medical Center in Chicago, said he was impressed by the students' results. "Your lists are remarkably on target," he said.

Next, the students discussed how to best assess whether candidates had those traits, and they discussed letters of recommendation, letters from the dean, personal statements, CVs and, of course, the all-important interview.

The final step was reaching consensus on three candidates. "Look for things that really set them apart," said Karen Weinstein, MD, assistant program director of internal medicine residency at West Suburban Hospital Medical Center in Oak Park. "For instance, being called 'pleasant' is generic, but noting 'one of the best students I've ever worked with' would make me sit up and take notice."

Daniel Girzadas Jr., MD, assistant program director for emergency medicine at Christ Hospital and Medical Center, advised his group to "look at how well the candidate performed on his or her specialty rotation."

Dr. Boyd gave the students an unofficial way to assess potential residents. "My secretary weeds out a dozen candidates each year because they're rude to her on the phone. These same people will probably

(Continued on page 8)



Medical students listened intently as residency officials from Chicago-area hospitals explained what they look for in candidates for their programs.

Turning the residency

(Continued from page 7)

also be rude to nurses, physical therapists, radiologists and everyone else they work with."

In another session, Ann Cole, of Ann Cole Communications in Chicago, advised the students to "be prepared, be yourself and be interesting. This may sound simple, but it takes a lot of practice to incorporate all three of these into your communications bag of tricks."

To be interesting, "be aware of the impact of body language; it should always enhance and support your words," Cole

advised. "Keep your answers short, narrow the focus to a key point in a very broad question and use 'power pauses' to create emphasis and show a thoughtfulness in not shooting from the hip."

To illustrate her points, Cole showed the students videos featuring examples of likability (Olympic figure skater Scott Hamilton), credibility (the founders of Ben & Jerry's Ice Cream), unpreparedness (Daryl Hartley-Leonard, spokesperson for Hyatt during the salmonella poisoning crisis) and insincerity (Lawrence Rawl, chairman of Exxon, talking about the oil spill).

Students also learned from Cole how

to use commonly asked but difficult questions as a springboard to achieve their objectives and personal agenda. The groups discussed how to answer the question, Do you have a problem carrying out do-not-resuscitate orders? One group developed the answer, "If I've explained it well enough and the patient has thought it out, not only do I feel comfortable, but I feel it's my responsibility." Another group said, "People have a perfect right to make decisions regarding not only their lives but their deaths."

To the all-encompassing request to "tell me about your family," one student answered, "My family includes my father

who's 55 and working his way through a world history series, my sister who's 17 and wants to be a nurse and a cat who's much too healthy for her age." Cole praised the answer for "using humor in a meaningful and positive way."

She reassured the students that "you have the upper hand on interview day. The training program must sell itself to you." However, Cole urged attendees to show a "high level of enthusiasm, even if you have to fake it. Dredge up the last remnant of energy you have."

Practical advice was also offered by residents who shared their personal interview experiences. "Obtain a list of who will be interviewing you and look up their research on Medline so you can ask smart, relevant questions," recommended Mitch Glaser, MD, child psychology resident at Children's Memorial Hospital in Chicago, a member of the ISMS Resident Physician Governing Council and an AMA Resident Physician Section member of the Council on Medical Services.

"Meet as many people as you can on interview day and get to know them," suggested Betty Chang, MD, chairman of the ISMS Resident Physician Section Governing Council and an internal medicine resident at Northwestern Memorial Hospital in Chicago. "You'll be spending more time with them than with your spouse or girlfriend/boyfriend. A very appropriate question to ask is, Would you stay here if you had to do it all over again?"

Northwestern internal medicine resident and MSS Chairman in 1995-96 Balu Natarajan, MD, said, "Don't limit your contact to those interviewing you, but ask other students and residents coming off call what it's like to work there." ■



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REPORT for Illinois Physicians

SOME OF US ARE MOVING! IMPORTANT CHANGES IN CHICAGO

The Chicago headquarters of your Medicare carrier, Health Care Service Corporation (HCSC) is moving. During September the staff will be relocating just a few blocks away from its current location. The move has been planned in such detail that service to customers will not be impaired. The important details are noted below:

Telephone Numbers

The only change in telephone numbers is for those numbers with area code 312. While the new headquarters remains in the 312 area code, the telephone prefix will change from 938 to 653. So, if you are calling someone whose extension is known:

- dial the 312 area code
- dial the new prefix 653, and
- dial the four-digit extension you have always used to reach that person.

The new HCSC telephone number is (312) 653-6000.

Address Change

Send medical policy comments for the Illinois Medical Director, Dr.

Douglas E. Busby, M.D.
Medicare Medical Director
300 E. Randolph Street, 13th Floor
Chicago, Illinois 60601-5099

All other addresses for carrier functions are unchanged.

Former ISMIS board chairman dies

Former chairman of the ISMIS Board of Directors Clifton Reeder, MD, died this summer after almost 50 years of participation in organized medicine. Dr. Reeder was a member of the ISMIS board from 1979 to 1986, and served as its chairman in 1982 and 1983.

Dr. Reeder was a retired internist living in Englewood, Fla.

After 20 years as a member of the ISMS House of Delegates, Dr. Reeder became vice speaker from 1979 to 1981 and speaker from 1981 to 1983. He was a member of the ISMS Board of Trustees from 1983 to 1984. He also participated in numerous Society councils and committees, and was an alternate delegate to the AMA. Dr. Reeder was president of the Chicago Medical Society for the 1978-79 term.

From 1972 to 1992, Dr. Reeder was medical director and chief executive officer of the Bodimetric Profiles Division of the American Service Bureau, a company conducting investigations and research for insurance companies.

Dr. Reeder is survived by his daughter, Susan Reeder-Kraus; his son, James Reeder, MD; two stepsons, Allen and Robert Hardy; two stepdaughters, Carolyn McCabe and Elizabeth Klein; three sisters; and five grandchildren.

Positions and Practice

Eldorado – Family practice, one-to-six call. Rural Health Clinic designation enhances optimum reimbursement. No Ob. Practice 4.5 days per week and earn \$150,000, more than the top 80 percentile nationally. Service 21,566 residents. Great schools and great athletics. Borders the Shawnee National Forest, our outdoor playground. Visit our Web site at www.sih.net/recruit. Send e-mail to recruit@sih.net or call (800) 333-1929.

Chicago and suburbs – Family practice, Ob/Gyn, internal medicine, pediatrics and most subspecialties: If you are giving any consideration to a new practice, you may find M.J. Jones & Associates your best resource. We are located in the Chicagoland area and know the communities, hospitals, groups, etc. We have an eight-year record assisting hundreds of physicians in the Chicagoland area. You can reach us 24 hours a day, seven days a week, at (800) 525-6306. We think you will be amazed at the difference! M.J. Jones & Associates, Naperville Financial Center, 400 E. Diehl Road, Suite 300, Naperville, IL 60563. Fax to (630) 955-0520; e-mail to dr2chicago@aol.com.

Psychiatrist – Outstanding opportunity for a BC/BE psychiatrist to join two psychiatrists in a newly developed, regional mental health center in Peru. Includes a 20-bed psychiatry unit, a one-to-three call schedule, competitive salary or income guarantee and a comprehensive benefits package. Peru, with a patient base of 120,000, is located in the beautiful Illinois Valley. With excellent schools, diverse cultural opportunities, a low cost of living and abundant recreational activities such as sailing and cross-country skiing, Peru offers superb quality of life. Contact Steve Baker at (800) 430-6587 or fax CV to (309) 685-2574.

Radiology residency now open – Unexpected opening for a first-year diagnostic radiology resident with the Southern Illinois University School of Medicine and affiliated hospitals in Springfield. ACGME approved. Candidates must have one clinical PGY to be eligible. This program has a total of 13 residents and 30 subspecialty-trained staff radiologists. Offers state-of-the-art equipment and extensive hands-on experience. Teaching hospital since 1972, residents on staff since 1978. Please fax CV to Kevin Coakley, MD, at (217) 525-5671.

Radiology residency open Sept. 1, 1998 – Opening available for first-year diagnostic radiology resident with the Southern Illinois University School of Medicine and affiliated hospitals in Springfield. ACGME approved. Candidates must have or be completing one clinical PGY. Contact Kevin Coakley, MD, program director, 800 N. Rutledge, Springfield, IL 62781; or phone (217) 785-2434.

Internal medicine – BC/BE internist needed for clinic in Downstate rural underserved area. Experience in cardiology a plus. Send replies to Box 2310, % Illinois Medicine, 20 N. Michigan Ave., Suite 700, Chicago, IL 60602.

Opportunities available in Chicago, suburbs and statewide for physicians in all specialties. Many unadvertised positions that will be tailored to meet your needs and salary requirements. For a confidential inquiry, contact Debbie Aber, Physician Services, 1146 Parker Lane, Buffalo Grove, IL 60089. Call (847) 541-9347 or fax to (847) 541-9336.

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51-100 words: \$90 per issue

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Frequency discounts:

50 words or less, 6 issues:	\$45 per issue –	\$270 total
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Illinois Medicine will be published every other Tuesday except the first Tuesday of January and July; ad deadlines are four weeks prior to the issue requested. Although ISMS believes the classified ads contained in these columns to be from reputable sources, the Society does not investigate the offers made and assumes no liability concerning them. The Society reserves the right to decline, withdraw or modify ads at its discretion. Ads will be edited to conform to Illinois Medicine style.

Peoria – Part-time family physician or internist. The Community Clinic of OSF (Sisters of the Third Order of St. Francis) is the realization of the OSF mission to provide health care to all individuals regardless of ability to pay. Need a family physician or internist to work two to four days a week, 8 a.m. to 5 p.m. Will see 20-30 patients a day. The clinic is located next to the OSF Saint Francis Medical Center, a 750-bed Level I trauma center. Salary is competitive. Call Wendy Bass at (800) 462-3621 or fax CV to (309) 685-2574.

Federal and state loan repayment available through employment in Illinois. Variety of urban and rural locations. Positions in family practice, obstetrics, internal medicine, pediatrics. Competitive financial packages, complete benefits, malpractice coverage, CME, paid vacations, holidays, etc. Contact Steve Carlson, Illinois Primary Health Care Association, 600 S. Federal, Suite 300, Chicago, IL 60605. Call (800) 682-1300, ext. 16. No J1s until October.

Permanent part-time physician wanted to do histories and physicals. Call (800) 898-0193.

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Internist – Seeking board-certified internist for expanding prominent internal medicine practice in northwestern suburb in McHenry County. Great family-oriented community with easy access to the city. Part time with no call and full time with shared call available. Competitive salary. Send CV to Box 2309, % Illinois Medicine, 20 N. Michigan Ave., Suite 700, Chicago, IL 60602.

BC/BE family physician or med/ped – Peru, Ill. Call schedule of one-to-three will be shared with an area FP. Practice is 50 percent pediatrics. Illinois Valley Community Hospital in Peru is a 108-bed facility affiliated with OSF Healthcare. The tri-county draw is 120,000. The position offers a competitive salary and a comprehensive benefits package. Please contact Wendy Bass at (800) 462-3621 or fax CV to (309) 685-2574.

Central Illinois Medical Review Organization is seeking actively practicing physicians to perform utilization review, DRG validation and quality-of-care review for its medical peer review program. All specialties needed, including adult and child/adolescent psychiatry, physical medicine, oncology, adult and pediatric neurology and neurosurgery, infectious disease, orthopedics, otolaryngology, obstetrics, addiction medicine, general surgery and most pediatric subspecialties. Physicians must have active admitting privileges at an Illinois hospital. For information, please call the resource development department at (800) 635-9407. Training and compensation are provided. EOE.

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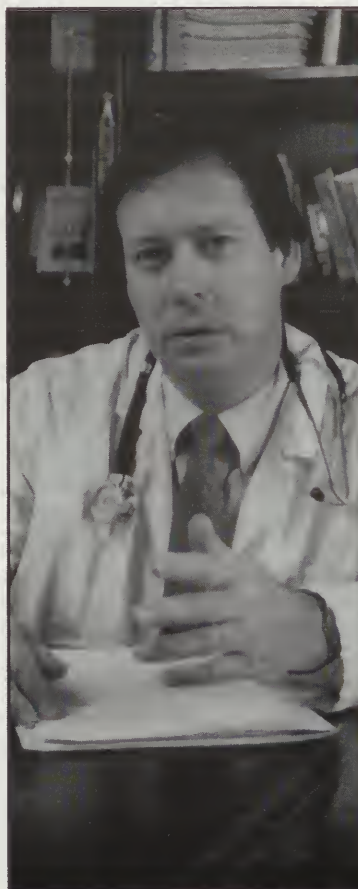
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Federal funds

(Continued from page 1)

sion of medical programs. "There's going to be a trade-off between listening and speed. And if you want to make that trade-off on the listening side, that's OK, but that means children will go without services longer. And if you want to make it on the other side, it may mean we're going to have to muscle down and compromise more quickly."

One hurdle is the matching state funds Illinois must provide to receive its share of the federal money, Hovanec said. For every dollar spent on the program, the state must provide 35 cents and the federal government, 65 cents, according to an ISMS analysis. So, if Illinois requests the maximum amount available in federal funds, it must provide \$66 million of its own money to receive \$122.5 million in federal funds. The program's total budget could be \$188.5 million.

The federal law also allows up to 10 percent of the program's federal money to be used for administering the program and for related outreach. This is an important element of the federal law because parents need to be educated about the new insurance option available for their children, according to Hannah Rosenthal, HHS regional director.

A state children's health insurance program may be implemented in one of three forms, according to federal law. Medicaid eligibility can be expanded to include currently uninsured children, a new program can be created or those two options can be combined. Some forum attendees suggested using the second option to include a children's health initiative as part of the state's Comprehensive Health Insurance Plan, a program that issues insurance policies to Illinoisans who are considered uninsurable. But most attendees said they'd prefer expanding Medicaid.

"I probably feel most comfortable as a state policy-maker seeing this move through the Medicaid program," said Sen. Steven Rauschenberger (R-Elgin), chairman of the Illinois Senate's Appropriations Committee. "Medicaid is an established and understood program." Medicaid expansion might also provide continuity of care for children by preventing them from bouncing between

state health care programs, he said.

Still to be decided is which state agency – IDPA or the newly created Illinois Department of Human Services – will administer the program. "We are knee-deep at this point in discussions with the Department of Public Aid and the governor's office with some early ideas about how we can put a plan together," said Ann Patla, IDHS associate secretary.

Federal law states that children under age 19 should be covered if they meet certain eligibility requirements like a family income that falls within a designated range, according to an analysis by

Abigail English, an attorney with the National Center for Youth Law, Chapel Hill, N.C. One implementation problem would be identifying those children and finding computer and eligibility systems to help them get care, Hovanec said.

IDHS would like to see community integration at all levels in the final design of the program, Patla said. "One of our missions is to find new prevention efforts and services so we can invest up front and not pay as much later. We would like to see all of the family clinics, the local county health departments, all of those other entities, be a part of the whole plan."

Whatever plan Illinois does finally

develop, it will be only part of the solution to problems related to the health of low-income children, according to program participants. "We can't be led into assuming that simply because we expand health insurance for children and adolescents, whether that be through the Medicaid program or through some other insurance expansion initiative, that we've solved the problem of children's health," English said. "We have not. All we will have done is expanded the opportunities for children and adolescents to now have health insurance coverage." ■

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Medical education

(Continued from page 1)

drawbacks. "It's taken us 25 years to increase and sort of meander up to the [current] level of physicians, and what they're going to do is try to cut that over the next three years," said Dr. Orlowski, who is also an ISMS Third District trustee. "This will be a financial burden to the academic medical centers."

Budget constraints will cause academic medical centers to reduce their capital investments and research funding and create problems in attracting the most qualified faculty, Dr. Orlowski said. "You will see tuition increases across the United States," she added. The communities in which medical centers are located will feel the cuts too. "There will be a loss of jobs when you cut \$15 million out of an academic medical center's budget," she noted.

Rush plans to eliminate any fellowship not approved by the American College for Graduate Medical Education and is considering consolidating programs. ■




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PAGE 8

Illinois Medicine

ILLINOIS STATE MEDICAL SOCIETY • NOVEMBER 7 1997

Business groups want physician data

PAGE 2

High court exempts hospitals from corporate practice of medicine ban

DECISION: Hospital subsidiaries may not employ physicians. BY JANE ZENTMYER

[SPRINGFIELD] On Oct. 23 the Illinois Supreme Court ruled 5-2 in *Berlin vs. Sarah Bush Lincoln Health Center* that the state ban on the corporate practice of medicine does not apply to licensed hospitals.

"While we are disappointed that the court reversed the Appellate Court's decision, we are pleased that it let stand a system that should help assure quality health care for patients," said ISMS President Jane Jackman, MD. "But it appears that the Supreme Court's decision allows only hospitals to employ physicians, not any other type of corporations or even subsidiaries of hospitals."

That means the court's decision doesn't affect as many physicians as it could have, explained ISMS General Counsel Saul Morse. Licensed hospitals that directly employ physicians, such as emergency department physicians, are not violating the corporate practice of medicine

ban. However, community clinics that are hospital subsidiaries and employ their own physicians may still be violating the ban, Morse said. "This is about as narrow a decision to reverse [the ban] as possible."

"The Supreme Court made a policy decision to change the law, most likely because it did not wish to adversely affect hospital-physician employment contracts already in place," said D. Cameron Dobbins, the attorney representing Richard Berlin, MD, and a partner with Dobbins, Fraker, Tennant, Joy & Perlstein in Champaign. "Any change in the law should have come from the Legislature, where physicians would have had an opportunity to participate in the process."

The case began in 1994 when Dr. Berlin resigned from the Sarah Bush Lincoln Health Center in Charleston to begin working just one mile away at the Carle Clinic Association's

Mattoon-Charleston branch. Sarah Bush Lincoln sued to prevent Dr. Berlin from practicing at Carle, based on an employment contract prohibiting his affiliation with "any person, firm or corporation engaged in competition with the hospital in providing health care services within a 50-mile radius" for up to two years after the contract ended. Dr. Berlin eventually left Carle, set up a private practice and sued the hospital for violating the ban on the corporate practice of medicine.

The justices based their decision on the extensive changes in the health care industry since the court's last ruling in 1936 and the need for hospitals to fulfill their independent duty to provide for patients' health and welfare. "The courts of several states have determined that the corporate practice of medicine doctrine is not applicable to hospitals [that] employ physicians," (Continued on page 10)



John McNulty

WALKERS WAIT FOR INSTRUCTIONS before starting on the American Diabetes Association Northern Illinois Affiliate's Walktoberfest Oct. 5 along Chicago's lakefront. Participants collected more than \$256,000.

Withdrawal of diet drugs leaves some patients lawsuit-hungry

FALLOUT: Physicians, attorneys and patients will deal with aftermath. BY LINDA MAE CARLSTONE

[CHICAGO] If the phones ringing at the Chicago law firm of Balkin & Doran Ltd. are any indication, a glut of lawsuits could soon land in Illinois courts filed by patients complaining that their health was damaged by two diet drugs pulled off the market by the U.S. Food and Drug Administration.

The firm has had an overwhelming response to its commercials soliciting clients who may be suffering side effects from the use of fenfluramine and dexfenfluramine, according to Charles Balkin, a plaintiff attorney specializing in personal injury claims. Balkin said the number of calls has been three times what he anticipated, although he declined to reveal the specific number of inquiries.

The attorney said he is now sorting through the complaints to distinguish those people who were truly harmed by the drugs from those who may be suffering from symptoms that are probably unrelated to the pills.

For physicians who prescribed either of the drugs, the first shoe dropped in July when the Mayo Clinic released results of a study linking the off-label use of the combination of fenfluramine and phentermine, or fen-phen, with valvular heart disease. In 1996 alone, fen-phen prescriptions in the United States exceeded 18 million. In September, the FDA pulled fenfluramine off the market, along with another diet drug, dexfenfluramine, or Redux.

Fen-phen-related class-action lawsuits have been filed in about 25 states, including Illinois, said Gary Mason an attorney with the Washington, D.C., firm Cohen, Milstein, Hausfeld & Toll. Mason said his firm, which specializes in class-action cases, has filed fen-phen suits in 20 states, including Illinois.

Physicians who have prescribed the drugs must now wait for the other shoe to fall, when they learn if they will be drawn into the legal hullabaloo.

(Continued on page 14)

ISMS issues guide on Illinois HMOs

FINANCIAL BLUEPRINT: Information is available on 42 plans that were in operation last year.

BY LINDA MAE CARLSTONE

[CHICAGO] Patients shopping for an HMO and physicians considering participation can get some help from the 1997 Guide to Illinois Health Maintenance Organizations, a financial blueprint of the 42 plans that operated in the state in 1996. There's nothing typical about Illinois HMOs, with plans averaging as much as \$5,122 per member on health services or as little as \$542 per member, according to the guide.

"There are large swings in amounts Illinois HMOs invest in patients," said ISMS President Jane Jackman, MD. "The guide will help consumers select a plan that will give them the best deal for their health care dollar." The guide is not intended as a one-stop resource but rather a starting point for fur-

ther research into the reasons behind the facts and figures, she noted. "An HMO with excessive overhead, for example, would probably deserve a close look at whether its quality of care is sufficient."

Physicians can use the guide to determine the financial shape of HMOs they are considering contracts with, Dr. Jackman said.

Employers can use the profiles to help them choose plans for their employees, she continued. "Employers should do more than compare premiums. They also should get an overall picture about availability of services."

This second annual edition of the guide includes individual pages for each HMO to help readers easily compare plans. The information was compiled

(Continued on page 14)

INSIDE

Van service
takes rural
patients for a ride



PAGE 3

Testimony
practice makes
perfect

PAGE 6

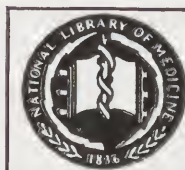
DEPARTMENTS

Malpractice
Roundup.....7

Classifieds11

IDPR
Disciplines13

NAT
SER
BLD
360
BET



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MEDICINE

Business groups want physician data

HEARING: Managed care reforms should include disclosure of information about doctors. BY THERESA GRIMALDI OLSEN

[BLOOMINGTON] Some business groups have called for a directory of data about physicians similar to the type of information physicians have sought about managed care plans, according to testimony presented at a hearing of the Illinois Senate's Managed Care Subcommittee held Sept. 17 at Illinois State University in Bloomington.

"To wisely choose among available

health care providers, consumers and purchasers should have easy and timely access to information about the capability, accessibility, financial arrangements and performance of individual practitioners," said McLean County Chamber of Commerce Assistant Director Sharon Tavana. She also spoke on behalf of the 11-state Midwest Business Group on Health, which has called for the collec-

tion and distribution of data about physicians and physician groups.

The Midwest Business Group on Health seeks 23 types of data about individual physicians, including history of malpractice litigation and claims, disciplinary actions, areas of board certification, length of experience in treatment specialties, frequency of performance of specific procedures and treatments, locations of treatment sites, fee schedules, incentive arrangements with specific health plans, patient satisfaction survey ratings and risk-adjusted morbidity and mortality rates for specific treatments.

"From the patient perspective, one of

the most frustrating decisions in health care is selecting a provider," Tavana said, adding that patients usually know only the name and specialty of the physician they've chosen and the location of the office.

After the hearing, ISMS President Jane Jackman, MD, said that one problem with physician profiling is that it needs to be put in context. "Recent studies show that the likelihood of being on the receiving end of a lawsuit is more related to adverse outcomes and communication skills than to malpractice. Malpractice records can be confusing, since often the best doctors are at highest risk because they care for the sickest patients."

ISMS has opposed previous legislative efforts to require the disclosure of malpractice information.

The subcommittee also heard testimony about the managed care utilization review process. Dr. Jackman told the panel that UR programs can interfere in the physician-patient relationship. "Patients ought to be able to know that utilization review decisions are made by people with the training, skill and competence to make them, based on criteria shaped by sound scientific evidence."

Dr. Jackman said that UR programs should be managed by medical directors who are physicians licensed in Illinois. Those directors should have responsibility for all clinical decisions made by the programs and for assuring compliance with quality standards.

UR programs should include a screening process based on sound scientific principles and developed in cooperation with practicing physicians and consumer representatives, Dr. Jackman continued.

When claims are denied as being medically unnecessary, patients and physicians should be allowed to appeal, Dr. Jackman said. In addition, the names and credentials of the professionals reviewing the decisions of physicians and other providers should be disclosed.

Utilization review was created to provide affordable health care to consumers, according to Sue Ashley-Lakin, a nurse who serves as an account executive for CorVel Corp., a UR company in Peoria. "We are just trying to make it as affordable as possible. We see a lot of different treatment plans for the same diagnosis."

Jeff Mays, executive vice president of the Illinois Chamber of Commerce, said that many of the chamber's 5,000 members use UR companies because health care gobbles 10 to 15 percent of their operating costs.

"Physicians are the final arbiters of review decisions," said G. Kristin Crosby, MD, national medical director of group health for Intracorp, a Pittsburgh-based UR firm that operates in Illinois. Between 1 percent and 2 percent of the cases reviewed by Intracorp are denied, but that figure would be much higher without UR, Dr. Crosby said.

To prevent interference in the physician-patient relationship, changes need to be made in state law, as has already happened in Texas and Missouri, Dr. Jackman said. Managed care plans should be held liable for decisions that adversely affect patients. "When a plan denies payment for a service, it is effectively denying the patient that service in most instances," she said. "Patients often cannot afford to pay out-of-pocket. So, the decisions a plan makes are not just about payment for the practice of medicine, but essentially the practice of medicine itself." ■



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REPORT for Illinois Physicians

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Blue Cross/Blue Shield of Illinois has just completed the move to its new building at 300 East Randolph Street in Chicago. Our new headquarters will be much more than just a new place to work; it will also allow us to work together in new ways.

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We frequently seek opportunities to meet with Illinois Physicians, their specialty organizations, or other "ad hoc" groups. The resources available to us and to you in our new offices should facilitate these meetings. We look forward to showing you our new corporate home, and sharing our conference facilities with you.

Macoupin van takes patients for a ride

INITIATIVE: When limited rural transit options strand those without wheels, service steps in. BY LINDA MAE CARLSTONE

[CARLINVILLE] At 72 years old, Delos Six gets around pretty well in his small town of Virden, particularly with his wife, Lois, by his side. But long-distance drives are out of the question. "His memory is not up to par," Mrs. Six said.

So when his kidneys failed last year, demanding frequent dialysis treatments, Six was faced with a 25-mile trip to Springfield three times a week and no easy way to get there. "At first my cousin was taking me, but she works, so that made it kind of bad," he recalled. For a short time he received rides from a Pittsfield service organization, but the program was canceled. Then last summer, the Macoupin County Public Health Department came to the rescue with a new program that assists residents who have no way to get to primary and preventive health services.

The lack of medical transportation is a common problem in rural areas where typically there is little or no public transportation and the population is spread out, said Kent Tarro, Macoupin County Public Health Department administrator. That description fits Macoupin County, the sixth largest county in the state with 872 square miles and 50,000 residents.

"We are a big bunch of small towns," said Tarro. The county does have two small hospitals, one in Carlinville and one in Staunton, but they are a 15- to 20-mile jaunt from the outskirts and don't offer some advanced treatments.

A 1993-94 assessment conducted by the Macoupin public health department concluded that lack of transportation was one of the main barriers to health care. The problem is exacerbated for senior citizens, the poor and the disabled, many of whom can't drive or don't own vehicles.

The health department devised a plan to attack the problem, a van service to shuttle patients to health care providers, but it could not afford the solution until the county teamed up with the Southern Illinois University School of Medicine at Springfield. Under the partnership, SIU purchased a six-passenger handicapped-accessible Dodge minivan for \$38,500 using money made available through the Rural Health Initiative, a state program to improve health service in Downstate and rural Illinois. Since 1993, ISMS has supported implementation of and funding for the initiative.

Macoupin County's transportation plan fit perfectly with the program's mission of matching resources with

community needs, said John Record, SIU assistant dean for rural and alumni affairs.

The county pays ongoing expenses, including maintenance and drivers. Rides are scheduled in advance, and users are asked to pay a nominal \$2 donation for in-county rides and \$5 for out-of-county trips. The service is available within a 50-mile radius from Springfield to St.

Louis. Technically, rider eligibility is an income level under 200 percent of the federal poverty level, but Tarro said no one is refused. Some residents don't qualify economically, yet they are isolated and don't have anyone to drive them, he said. Almost 90 percent of the riders are senior citizens, which Tarro said is not surprising, since 26 percent of the county population is over 65.

The program concentrates on prevention: regular checkups for dental work, eye exams and the like. "Some young parents use the rides if they don't have a way to carry their babies across town to the pediatrician," Tarro said.

Typical van trips take patients to physicians, hospitals, clinics, dentists, public health clinics, mental health counselors, alcohol and substance abuse counselors and rehabilitation service counselors. Ridership is increasing steadily as news of the service travels and is now up to about 40 rides a month, Tarro said.

Users requiring lengthy treatments, such as Six's dialysis, are given rides if necessary, but the program tries to connect these patients with a volunteer pool operating side by side with the van service. "We want to provide access to as many people as possible," Tarro said. ■

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EDITORIAL

A little help with HMOs

HMOs nationwide are expected to hike premium rates by at least 5 percent next year, double the average increase in 1997 and the rate of inflation, according to news reports. Industry analysts say HMOs need to make up for profit losses after they froze or cut premiums in what has been a very competitive market. The federal government has also agreed to an average 8.5 percent increase under the 350 health plans that cover federal employees, which was called a "bellwether of what we'll see in rates" by the president of Kaiser Permanente's Rocky Mountain division.

What are the specifics behind the increase? Competition has weeded out the field, leaving the survivors to seek higher rates; and physicians and hospitals have formed stronger bargaining units, according to the New York Times. Another factor has been mounting expenses – investment in information systems, difficulty in controlling costs for Medicare recipients and expanded patient choice, reported the Chicago Tribune.

In a Gallup survey of HMO and PPO senior executives, 34 percent said the biggest challenge they face is controlling costs while delivering quality care.

Spiraling costs were blamed for third-quarter shortfalls experienced by Aetna Inc. and Cigna Corp. After news of the losses was released, shares of both companies dropped. In October, Prudential Insurance Co. of America decided to sell its health care business.

Oxford Health Plans has fallen behind in paying physicians, according to the Wall Street Journal. In fact, the New York state attorney general recently forced the company to pay interest on claims that had gone unpaid for 30 days. Oxford is trying to reduce costs by contracting with 700 specialists to take full charge of cases for a set flat fee based on an agreed-upon schedule.

Here in Illinois, the Illinois Department of Insurance announced that it was requiring several financially weak HMOs in the state to boost their net worth.

All these events happened just last month and are a snapshot of some of the rapid changes taking place in HMOs, especially in the financial area. These changes will force employers to make tough decisions and consider tradeoffs between cost, quality of care and access.

To help employers, patients enrolling in HMOs and physicians considering participation in HMOs, ISMS released the 1997 Guide to Illinois Health Maintenance Organizations. The guide covers the 42 HMOs that operated in Illinois in 1996 and is based on annual reports the HMOs must file with IDOI. The data – such as the amount and percent of each HMO's income spent on medical care, administrative costs and profit/surplus – is a good foundation from which to develop questions for the HMOs.

Employers and patients need to make informed decisions to get maximum value for their premium dollars.

PRESIDENT'S LETTER

All managed care plans are not created equal

Jane L. Jackman, MD



The ISMS and NCQA studies should be a good starting point for patients and businesses that want to become better-educated health care consumers.

More than 2 million Illinois citizens used HMOs for their health care in 1996, up almost 14 percent from the previous year. We expect that number to continue to increase, especially with the influx of Medicaid and Medicare patients into managed care systems in the near future. It seems that managed care and especially HMOs are increasingly a part of living and doing business in our state.

It also is becoming apparent that all managed care plans are not created equal. A recent report from the National Committee for Quality Assurance showed wide variation among plans in quality of care and service to their enrollees. NCQA President Margaret E. O'Kane said, "The range of health plan performance across the country and even within regions is striking."

The newly released ISMS 1997 Guide to Illinois Health Maintenance Organizations also shows differences among HMOs in our state. This guide is formulated from information from the Illinois Department of Insurance. It gives information on each plan's financial stability, as well as how much it spent on medical care vs. administration and profits. There is also a section on premiums and the number of complaints filed against each plan.

It is often very confusing for patients trying to figure out which plan they should select annually. Employers who have chosen a health plan or plans for their employees have had very little data on which to base their selections. Certainly, premium costs should not be the only deciding factor. The degree to which the plans care for their enrollees, patient satisfaction and choice of physician and hospital should also be very high on employers' and patients' checklists. The ISMS and NCQA studies should be a good starting point for patients and businesses that want to become better-educated health

care consumers and get more value for their health care dollars.

Useful as these studies may be, though, much more is needed to ensure that all patients receive quality health care in a timely fashion from their managed care plans. As Alan Steinberg, MD, author of "The Insider's Guide to HMOs," said, "To a certain extent, measuring what the HMO does is irrelevant. The person taking care of you is the doctor or medical group." Yet, medical decision-making in managed care often seems to be done by nonmedically trained clerks or by medical directors who have never seen the patient and may be physically many miles away from the exam room or hospital bed. The doctor-patient relationship seems to be crumbling at the edges. Patients are too often forced to change doctors, which further weakens this important relationship and doesn't allow for continuity of care.

What is needed is legislation to regulate managed care plans. Patients should be confident that all such organizations conform to a reasonable level of quality if they wish to do business in Illinois. The doctors who actually see the plans' patients should have more of a voice in setting medical policy. Gag clauses should be banned, and doctors should be encouraged to advocate for their patients' needs rather than being penalized. Information generated by managed care plans should be standardized and simplified so that patients can compare plans easily.

Your state medical society is working hard to pass H.B. 626, which encompasses these and other patient rights. It has already passed the Illinois House this year and is being heard in a state Senate subcommittee. I urge all of you to ask your senators to support the provisions in this bill. Our patients badly need the protections.

GUEST EDITORIAL

Public health at a turning point

By John Lumpkin, MD

In 1927, Illinois Gov. Len Small wrote, "Profound changes have taken place during the last 100 years in all departments of civilization, but in none has the transformation been more fundamental nor more nobly crowned with advantage than in the field of health. At the beginning of this period, man was little short of a helpless victim to infectious diseases that frequently swept over whole cities and nations in great lethal waves. Today, he is able to exercise a marvelous control over the factors involved in health, adding strength to his years and years to his life."

Since Small wrote those words, public health has greatly changed: Diseases have been conquered only to re-emerge in new, more virulent forms, and maladies unheard of two decades ago are exacting a frightening toll. Longer life spans have allowed chronic illnesses to

move aggressively to the forefront. In many cases, public health professionals have had to respond quickly and creatively to adapt to these changes.

As we approach the new century, significant new pressures will challenge the public health system and its future. If states, communities and public health agencies are to continue to protect and promote the health of Americans, we must strengthen public health. One way the Illinois Department of Public Health is preparing to do so is by competing for funds through "Turning Point: Collaborating for a New Century in Public Health," a grant program jointly developed by the W.K. Kellogg and Robert Wood Johnson foundations. The program has been designed to encourage and support strategic development at the state and local levels. This initiative recognizes the needs to broaden our defini-

tion of the public health stakeholders, create partnerships to address old and new problems, and design innovative collaborative approaches to improve the health of all Illinoisans.

All local health departments in Illinois were offered the opportunity to participate in the Turning Point initiative. The foundations have selected the state's proposal, Public Health Futures Illinois – along with proposals from local partnerships in Chicago, Decatur/Macon County, Will County, Peoria and 19 other states – to stay in the running for a Turning Point grant. The grants will be announced next month.

Public health faces major challenges in the public and private sectors. Those challenges include improving health care delivery, changing health-related behaviors and improving the environment. Two of the most recent issues facing public health officials are the increase in managed care penetration and the reorganization of Illinois' human services agencies.

IDPH convened a steering committee for our Public Health Futures Illinois proposal in February because we recognize that we cannot address these issues

by ourselves. This 32-member panel includes ISMS' immediate past President Sandra Olson, MD, as well as legislators, business and labor leaders, members of the religious community, health care providers, policy experts, and representatives of volunteer and membership organizations, public health organizations and academia. The committee has been formed to help IDPH and the public health community make decisions actively and clarify the role each party will play.

Over the past decade, the state's planning has strengthened the intergovernmental structure for public health. With Turning Point funding, we could enhance the public health system by developing strategic plans that involve new partners, each with a stake in improving health. With these partnerships in place, Illinois' public health system can continue to meet the challenges of today and tomorrow.



Dr. Lumpkin is the director of IDPH.

GUEST EDITORIAL

States target ERISA exemption

By Jane Bryant Quinn

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What's the Rx for patients injured by a health plan's decision to deny them critical treatment they should have had?

Patients can and do sue their doctors for medical malpractice. But their health insurers are usually off the hook. In most states, it's all but impossible to bring malpractice charges against an employee plan.

The plan may have told your doctor that it won't cover a particular treatment because it's not "medically necessary." If the doctor accepts that decision, however, and it turns out to be wrong, only the doctor can generally be held at fault.

The injustice of this is becoming increasingly clear, both to legislatures and the courts. Around the country, a movement is stirring to hold health plans accountable for the decisions they make. In May, Texas passed the first state law allowing patients to bring malpractice claims against HMOs and other managed care plans.

In June, Missouri achieved a similar result, by making it clear that HMOs practice medicine. This opens them to malpractice claims, Marla Rothhouse, a policy specialist at the Health Policy Tracking Service in Washington, D.C., told my associate, Kate O'Brien Ahlers. Connecticut has also opened the door a crack.

Some 20 other states are considering similar laws. Proposals are on deck in New Jersey, under study in Rhode Island and Washington state, and moving through the tortuous legislative process in New York and California (with no guarantee of results).

There are even two proposals at the federal level. Rep. Charlie Norwood, a Republican from Georgia, wants to

allow state malpractice actions if a health plan makes a medical decision that leads to injury or death. Rep. Pete Stark, a California Democrat, would create a federal malpractice law, available to injured patients in any state.

Federal appeals courts have also taken up the issue. Thanks to patient-friendly decisions, you can now sue in nine states: Delaware, New Jersey, Pennsylvania, Colorado, Kansas, New Mexico, Oklahoma, Utah and Washington.

In a few other states, malpractice cases have occasionally been allowed. A

majority of states, however, still bar them completely.

What insulates health plans from responsibility for their decisions? A federal law known as ERISA – the Employer Retirement Income Security Act of 1974. This law was originally written to protect the integrity of pension plans. But its wording covers all company benefits, including health insurance.

Under ERISA, claims against company health plans have to be brought in federal court. But malpractice is a state offense. If you sue in the state and your case is moved to federal court, your malpractice claim no longer exists, no matter how careless the health plan was.

ERISA covers only employer plans. You can sue for malpractice in state court if you buy your own individual plan.

Very few employer plans can be sued

even under current law. Who are the lucky employees? Members of Congress, naturally, who always look out for No. 1. Also state government employees.

The managed care plans whine that malpractice shouldn't apply to them because they don't make medical decisions. If they rule that a treatment isn't "medically necessary," they claim it's merely paperwork.

It's regrettable that lawsuits seem to be necessary. Florida Gov. Lawton Chiles vetoed a bill that would have allowed malpractice claims, arguing that lawsuits drive up medical costs. Consumers themselves don't want death claims, they want timely treatment.

But the HMOs and other managed care plans are bringing this backlash on themselves. When appeals are slow and there's no independent source of justice, where else can consumers turn?

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ISMIE Update

Practicing the art of testifying

LITIGATION: Preparation should include homework, role-playing and repetition. BY JANICE ROSENBERG

[CHICAGO] Whether they serve as defendants, witnesses in specific cases or expert witnesses, physicians who understand the trial process and the art of testifying will feel more comfortable at depositions and in the courtroom. Preparation can help doctors stay cool under pressure, and maintaining self-control facilitates listening carefully to questions posed by plaintiff attorneys, answering only the question at hand, giving complete answers and staying within each physician's area of expertise, according to Timothy Nickels, a partner at the Chicago law firm of Wildman, Harrold, Allen & Dixon. He spoke at an ISMIE risk management program called "The Art of Testifying" presented Sept. 30 at St. Joseph Health Centers & Hospital in Chicago.

Nickels emphasized the importance of preparing for the questions that are likely to be asked by defense and plaintiff attorneys. "You don't just get on the stand. You have to understand what it means, the venue and where you are in

respect to it."

Defendants in medical malpractice suits should meet with their own attorneys at least twice before pretrial depositions to review the case, anticipate the plaintiff attorney's questions and prepare answers to those questions.

"Take the time to know the patient's chart," Nickels advised. "A jury won't believe a doctor who says he knew a patient back then, if he doesn't know the patient now. Go over the chart and be sure you can read your own handwriting."

Role-playing is part of pretrial preparation. Nickels said he often plays the role of plaintiff attorney, firing tough questions at his client, while one of his partners acts as defense attorney. Conducting the exercise in a courtroom helps familiarize the physician with the trial setting, he said. Nickels said he even videotapes



John McNulty

Nickels

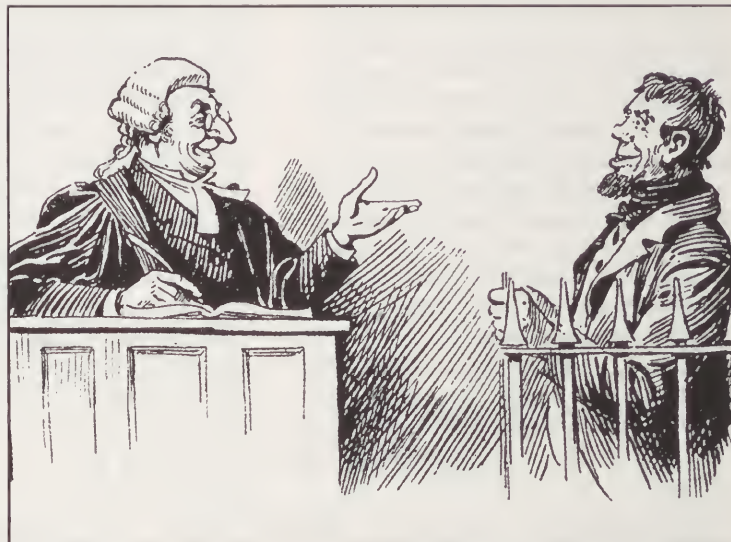
practice sessions sometimes to help physicians correct areas in which their responses were less than exact.

"After you've been asked the same question three or four times, it's hard to maintain self-control," said Richard Messersmith, MD, chairman of the radiology department at Lutheran General Hospital in Park Ridge. "Your urge to strangle the guy who's asking it is almost overwhelming."

Before testifying, physicians should do their homework and practice phrasing every answer in language a layperson would understand, Dr. Messersmith advised. He said that when he was a defendant, he talked to his wife about the case, explaining the facts of the case repeatedly until his description was refined and consistent and his wife could easily follow it.

Repeating the story helped reduce the chance of his flying off the handle while testifying, Dr. Messersmith said.

Direct testimony, in which physician defendants are questioned by their own attorneys,



allows doctors to tell their own stories. "You are the star in that part of the trial," Nickels said. "You're the teacher, explaining medical terms with analogies that the jury will understand. You should maintain eye contact with the attorney and the jury, and speak in simple language and a conversational tone."

Nickels advises his clients to ask the judge for permission to approach the jury. He also recommends the use of displays and diagrams to keep the jury interested. At the beginning and end of direct testimony, Nickels asks questions to establish the physician's credentials.

In addition to being defen-

dants, some physicians also enter the courtroom as expert witnesses. Dr. Messersmith said that serving as an expert can provide good experience. "Being sued is as inevitable as death and taxes. To be prepared, there's no better way than by serving as an expert witness once or twice. You can review the standard of care [for your specialty], and it will teach you to be objective."

"Be honest and impartial," Dr. Messersmith recommended. "Be more interested in giving the objective standards than in pontificating. And remember, appreciating the ironies of the case will lighten the load." ■

Failure to communicate leaves patient in the lurch

BY LINDA MAE CARLSTONE

The patient came to Dr. Myer for answers. Her hopes of enlisting in the U.S. Army had been dashed when she flunked the entrance physical due to an elevated protein count in her urine. She turned to Dr. Myer, an HMO gatekeeper, for diagnosis and treatment, but it took nearly two years to get answers. By then, her condition had progressed to advanced renal insufficiency and she was forced to undergo a kidney transplant.

The case in brief: On the first visit, Dr. Myer ordered a urinalysis that confirmed a 2+ protein. At that point, Dr. Myer, an Ob/Gyn, decided to

refer the patient to a nephrologist. The HMO informed him there was no nephrologist in the network and instructed him to send the patient to an internist. Records show no referral was made.

A week later, the patient returned to Dr. Myer, who said that he recalled referring her to an internist, Dr. Jeffries, and that he and Dr. Jeffries discussed what tests were needed. The records, however, don't support those details. Dr. Myer also ordered a urinalysis at this visit.

The record entry a week later stated that the lab report on the urinalysis was negative for pregnancy. When Dr. Myer was

CASE IN POINT



eventually notified that the patient had filed a lawsuit against him, he changed the entry from "protein" to "pregnancy." He explained he thought the lab technician who entered the note wrote "protein" inadvertently.

Ten days later, the patient returned to Dr. Myer complaining of a vaginal discharge, and he referred her to Dr. Jeffries. Six days later, the patient visited Dr. Jeffries. He sent her to the hospital for a 24-hour urine protein test and, according to

his notes, referred the patient to Dr. Myer for follow-up. This notation is believed to have been falsified because it was squeezed onto the margin of the page that documented the urine protein test. The test revealed a very high protein level of 3,187. (The normal range is 0-200.) Neither physician informed the patient of this reading.

Three months later, the patient experienced dermatitis and fatigue and saw Dr. Myer. She was again referred to Dr. Jeffries for a 24-hour urine protein test with the lab reporting a level of 2,605. Dr. Myer denied he received the reading, saying the hospital could have sent the results to another Dr. Myer. The

patient visited Dr. Myer 10 months later, and her urinalysis indicated a 3+ protein. Within a week, she was advised by letter of the abnormal results. At her final visit to Dr. Myer, she was referred to her internist, Dr. Jeffries, but refused to go.

Two years after her initial visit with Dr. Myer, the patient was diagnosed with irreversible renal insufficiency, and three years later, she underwent a kidney transplant. The patient sued both Dr. Myer and Dr. Jeffries, alleging they failed to properly monitor and treat her for the elevated protein readings.

The points this case makes:

Even though the care began in the right direction, it quickly deteriorated, according to Henry Martin-del-Campo, MD, a member of the ISMIE Ob/Gyn (Continued on page 7)

Failure to communicate

(Continued from page 6)

Risk Management Subcommittee, and the medical director of Health Alliance Medical Plans in Peoria. Dr. Myer was correct to send the patient to an internist when a nephrologist wasn't available. The 24-hour urine protein test was an appropriate next step after the urinalysis showed a 2+ protein. A test result in the 200-500 range, for example, would have required monitoring by an internist, but not the involvement of a nephrologist.

The trouble began with what didn't happen next. Despite the 24-hour test revealing the excessive protein count, neither physician followed up except to point fingers at each other after the fact. It's everyone's job to follow up on a patient, Dr. Martin-del-Campo said. "It was Dr. Jeffries' job to follow the patient and Dr. Myer's job to communicate [with Dr. Jeffries] and see that the patient was being followed. Transfer of care needs to be complete, and it needs to be in writing."

This case is a classic example of weak documentation, said Dorothy French, an attorney at Hinshaw & Culbertson's Lisle office. "Everything should be in writing; otherwise, no one will believe it occurred." Patient warnings should be well documented on the chart with notations such as, "Advised the patient of renal insufficiency; urgent to see Dr. Jeffries for follow-up," she said.

The patient in this case is also guilty of poor follow-up, but that does not relieve Dr. Myer of his obligation to contact the patient with abnormal test results and to confirm that the patient saw the internist, French said. If anything, her lack of attention to her own care could raise the question for the jury of whether she was informed of the severity and urgency of her condition. "The jury may decide no one ever talked to her."

A critical breakdown in this case was the test result that neither doctor examined, French said. "Many times the doctor relies on results being placed in the mailbox. The jury doesn't understand that. They think this is a doctor's only patient and that there should be an office procedure to collect results."

The case also spotlights the danger of altering records. "Medical records are a legal document, and once altered, you destroy your credibility," Dr. Martin-del-Campo said. "If you get caught, you will very likely lose the case." Still, he said, some physicians think they won't get caught if they make changes. Altered records are easily detectable by techniques that can reveal when the notation was made and whether the ink on one note matches the rest of the chart, he said.

Using copies isn't a good idea, either, he said. "Copies are viewed as highly suspicious. If you don't have originals, it will be assumed you altered records, and the plaintiff attorney will bring that to light multiple times during the trial to remind the jury." In addition, the most common way to catch altered records is by comparing copies of the same records: Copies that don't match are proof that something has been altered. ■

"Case in Point" uses hypothetical case histories to illustrate risk management maxims.

MALPRACTICE ROUNDUP

Patient takes control of medication, loses lawsuit

A Los Angeles Superior Court jury decided that a California physician acted within the standard of care while managing a patient's medication after a kidney transplant even though the patient rejected the kidney, according to the September issue of Medical Malpractice Law & Strategy.

In *Small vs. Agre*, the patient ini-

tially saw a physician to manage her three immunosuppressant medications – cyclosporine, prednisone and azathioprine. Five years after that first visit, she stopped taking cyclosporine, and 20 months after that, her prednisone dosage was reduced. Her body rejected the transplanted kidney five months after the prednisone reduc-

tion. The plaintiff attorneys claimed that by stopping the cyclosporine treatment and reducing the prednisone, the physician was using monotherapy, which was below the standard of care.

The physician responded that the patient decided to stop taking cyclosporine, and the prednisone modification was necessary because of pre-existing cardiovascular disease.

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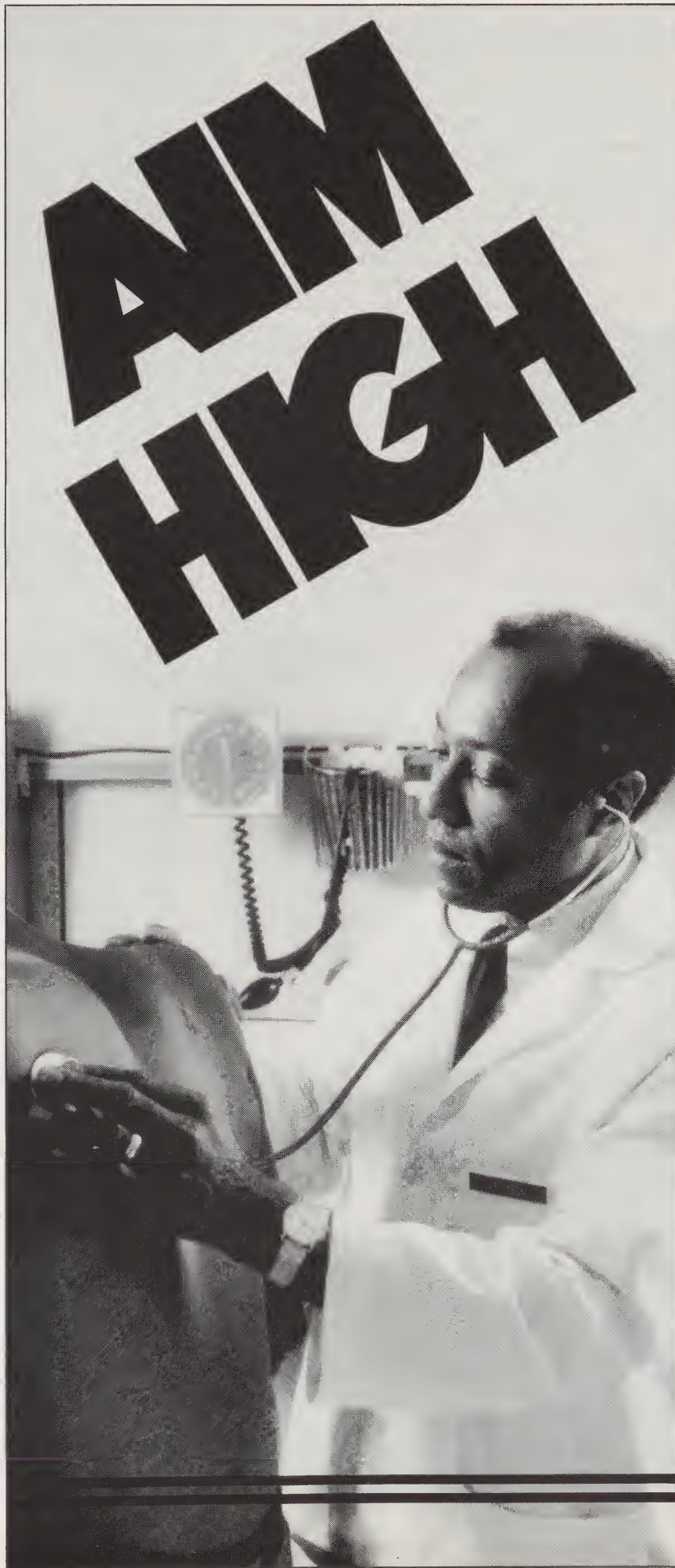
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Indian physicians help

Regardless of where they attended medical school, physicians

BY LINDA M

In medicine, some things are universal. At a meeting of Downstate physicians this fall, the conversation centered on concerns that dog most practicing physicians – how to preserve physician autonomy and quality patient care.

The occasion was the eighth annual convention of the Downstate Illinois Chapter of the American Association of Physicians of Indian Origin. The national organization, also known as the American Association of Physicians of India, or AAPI, is composed of more than 100 chapters nationwide. Guests of honor at the

convention, held at Southern Illinois University in Carbondale, included a U.S. representative, two members of the Illinois General Assembly and the mayor of Carbondale.

The evening banquet reflected the organization's objective to support its members in practicing high-quality medical care in the United States. Recently, managed care issues have made legislative activities a priority.

"We believe that all competent physicians should be treated equally regardless of their place of educa-



Dave Cutler/SIS

Build unity in medicine

are united on need for autonomy and quality patient care.

BY CARL STONE

Caesar Maragni



Harrisburg general surgeon Vinay Mehta, MD (left), and Dr. Sprang chat during the recent convention of the Downstate Illinois Chapter of the American Association of Physicians of Indian Origin.

tion or country of origin," said chapter President Jagan Ailinani, MD. "We all have a lot in common; we face the same problems." He added that his group works closely with the AMA and ISMS and that most of his organization's members belong to all three groups.

ISMS Chairman of the Board of Trustees M. LeRoy Sprang, MD, agreed that physicians must stick together. "We need to reach out to each other at this time when medicine is at a crossroads.

"If we let managed care divide us, we will lose, and patients will lose," continued Dr. Sprang, who was a featured speaker at the chapter meeting. He pointed out that ISMS and AAPI are in sync on managed care.

The ideas contained in the federal managed care patient rights bill that AAPI supports are similar to the Managed Care Patient Rights Act that ISMS crafted and state lawmakers considered last spring, Dr. Sprang said. "We are saying the same kinds of things."

AAPI is especially concerned about the "artificial hurdles being created in managed care" that determine who can and cannot participate in a plan, said national AAPI President Ranga Reddy, MD, an anesthesiologist from Springfield. "A physician can be removed without due process, which leaves room for discrimination. There is definitely a glass ceiling."

Another front-burner issue for AAPI is potential federal funding cuts for residencies, which the organization believes could target international medical graduates. "But they are not thinking about rural areas and inner cities," Dr. Reddy said. "If IMGs aren't here to fill those jobs, people in those areas will suffer." Cuts should be gradual, about 5 percent, so the program can be properly monitored and shortages can be avoided, he added.

Indian physicians have made important contributions to U.S. medicine, and that's one of the messages AAPI wants to make known to the country's leaders, said Dr. Ailinani, who is also secretary of the Jackson County Medical Society. In Illinois, Indian physicians have brought specialties like cardiology and urology to rural areas, so that patients no longer had to drive

100 or more miles for such services, he explained. They also hung shingles in small towns that lacked primary care physicians.

In numbers alone, physicians of Indian origin practicing in the United States have made an impact. About 30,000 strong, they compose almost 5 percent of the total 700,000 physicians in this country. They also form the largest group among the 130,000 IMGs practicing in the United States, accounting for about one-fifth of the total.

ISMS has been a leader in assuring equality for IMGs, according to Dr. Sprang. In 1989, the General Assembly passed an ISMS-supported bill that reflected House of Delegates policy and that made it "inappropriate to discriminate against any physician because of national origin or geographic location of medical education."

IMGs also participate widely in the ISMS house, Dr. Sprang said, adding that he expects their influence to increase. At the 1997 Annual Meeting, the house directed ISMS to establish an IMG section, and at next year's meeting, delegates will discuss additions to the bylaws to create the structure of that new section, he said.

At the national level, issues like residency funding cuts and federal managed care reform prompted AAPI to develop a stronger legislative presence in Washington, D.C. The organization opened a legislative office there about a year ago and hired full-time legislative director Neil Parekh. A contact system has been established to inform members about issues so that members can communicate AAPI's position to their legislators.



They are very aware of how the democratic process works, and they make full use of it. Their concerns are the concerns of all doctors.

Parekh said he often attends chapter dinners to meet with lawmakers from around the country. At the Downstate chapter's convention banquet, he chatted with a guest — U.S. Rep. John Shimkus (R-Ill.). After the convention, Parekh followed up with Shimkus' health care staffer to make sure she knew what legislation the organization was looking at. "I told her about our concerns," he said.

ISMS President Jane Jackman, MD, an IMG from Great Britain, praised AAPI for its political activism to help the cause of medicine. "They are very aware of how the democratic process works, and they make full use of it. Their concerns are the concerns of all doctors." ■

High court exempts

(Continued from page 1)

because hospitals are authorized by other laws to provide medical treatment to patients," wrote Justice John Nickels for the majority.

ISMS policy supports the ban on the corporate practice of medicine, and the Society filed an amicus brief supporting Dr. Berlin's arguments. But Morse said, "It should be remembered that our policy on employment of physicians is one that leaves the decision to the individual physician. It also states that where physicians are employed, there should be protections

for clinical autonomy and a means for independent review of employment determinations to protect that autonomy. Hospitals, through their medical staffs, provide an avenue to maintain that autonomy called for in ISMS policy."

President of the Illinois Hospital and HealthSystems Association Kenneth Robbins said, "We were pleased with the court's decision, but as important as it is for hospitals, it is just one of many other important issues that the medical community needs to address in the future."

Two justices dissented, arguing that the General Assembly has failed to amend the law despite ample opportunity in the 61

years since the Supreme Court's last ruling on this issue. In the dissenting opinion, Justice Moses Harrison wrote: "The Legislature is presumed to know the construction the courts have placed upon a statute. When it amends a statute but does not alter a previous interpretation by this court, we assume that the Legislature intended for the amendment to have the same interpretation previously given."

Harrison cited the renewal of the Medical Practice Act, which was signed into law before the Appellate Court issued its ruling in the Berlin case. The basis for the ban on the corporate practice of medicine is contained in the Med-

ical Practice Act, which allows for licensure of only individuals, not corporations. Exceptions are made for specific entities like HMOs. When the governor and legislators renewed the act early this year, however, they didn't substantively change the licensing requirements or add exceptions, Harrison wrote.

The court's decision in Berlin could also influence the outcome of Holden vs. Rockford Memorial Hospital, another case that challenges the ban on the corporate practice of medicine. Both lower courts upheld the doctrine in the Holden case, and the hospital has asked the Supreme Court to hear an appeal. ■

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May

Robert L. McEntyre, Bloomington – physician and surgeon license suspended for 30 days followed by probation for five years and controlled substance license revoked for violating the terms and conditions of a previously ordered probation.

Tadeusz Pawlisz, Chicago – physician and surgeon and controlled substance licenses revoked for diverting controlled substances for nontherapeutic use, refusal to turn over patient records even though authorized, falsifying patient records and violating a previous department order.

Jacob Ellryn Rocke, Palos Heights – medical license and controlled substance licenses placed on probation for two years for prescribing an increased strength of Valium without sufficient medical reason.

Philip Skoczelas, Chicago – physician and surgeon license reprimanded and fined \$5,000 for failing to properly supervise subordinate health care workers at a long-term nursing home.

Ignacio S. Solis, Chicago – physician and surgeon license indefinitely suspended for violating the terms and conditions of a previously ordered probation.

Kenneth Velez, Normal – physician and surgeon and controlled substance licenses placed on probation for one year for failing to log the dispensing of controlled substances, dispensing generic drugs with brand names on them and without patient names on the pre-labeled containers, self-prescribing Xanax, using his own samples of medication and demonstrating a pattern of behavior showing incompetence to practice medicine.

Woo Joong Yoon, Franklin Park – physician and surgeon license placed on probation for three years and controlled substance license placed on indefinite suspension for failure to keep controlled substances in properly secured areas, failure to maintain a record of controlled substances and selling codeine and diazepam to a person and selling Hydromet cough syrup to persons.

The following individual physician and surgeon licenses were placed on indefinite probation due to outstanding tax liabilities owed the Illinois Department of Revenue: Cesar Giannotti, Aurora, and Howley Stevenson, Chicago.

June

Richard Caldwell, Chicago – temporary physician and surgeon license issued on indefinite probation due to an alcohol abuse problem.

James Ying Chow, Arlington Heights – physician and surgeon license reprimanded and fined \$2,000 for aiding and abetting the unlicensed practice of acupuncture.

William Donoghue, Chicago – physician and surgeon license indefinitely suspended due to an outstanding tax liability owed the Illinois Department of Revenue for the years 1993 and 1994.

Ho Young Kim, Chicago – physician and surgeon license placed on probation for four years for perforating a uterus during two separate elective abortions.

Zahida Muzaffar, Naperville – physician and surgeon license reprimanded for improperly adding information to a patient's medical records.

Bright Yasunori Onoda, Chicago – physician and surgeon license reprimanded and controlled substance license revoked for dispensing controlled substances to his wife and failing to keep controlled substances in a secure place.

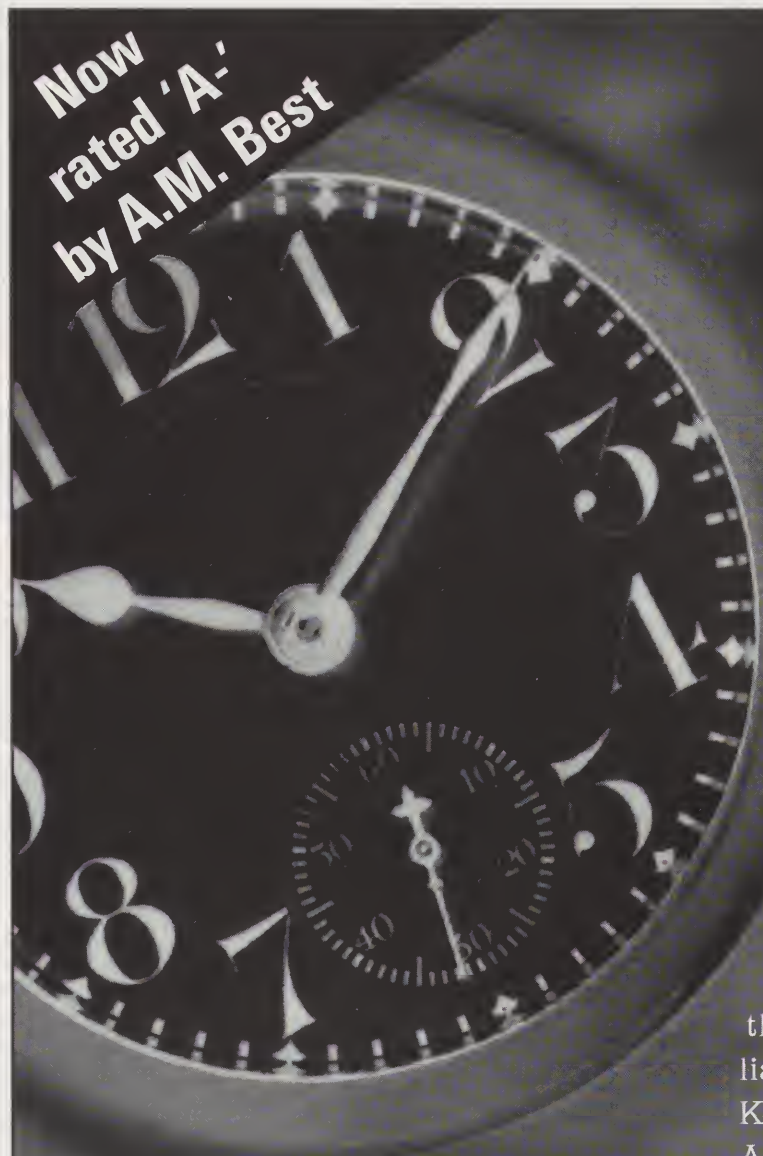
Eric Roy Sigmond, Arlington Heights – physician and surgeon license placed on probation for two years for allegedly engaging in sexual activity in the presence of a female patient.

Edward D. Sutoris, Chicago – physician and surgeon license placed on probation for one year for signing orders that did not provide for the insulin medication for one of his diabetic patients, resulting in her hospitalization; keeping records for this patient and other patients that did not meet the commonly accepted standards of the profession; and breaching his responsibility to his patients.

July

Richard Brady, Vandalia – physician and surgeon license revoked due to criminal indictment in LaSalle County for aggravated criminal sexual assault, computer fraud, aggravated insurance fraud, vendor fraud and theft, and violating the terms and conditions of a previously ordered department probation.

Steven D. Cochran, Hinsdale – physician and surgeon license reprimanded and fined \$500 for negligence in the pharmacological treatment of a patient with bipolar disorder.



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ISMS issues

(Continued from page 1)

from the annual reports HMOs are required to file with the Illinois Department of Insurance. Thirty-seven of the 42 HMOs operating in Illinois in 1996 were for-profit companies. Nine of the plans listed in the guide did less than 30 percent of their business in Illinois.

Each HMO was offered the opportunity to explain information reported in the guide, and comments were included. For instance, Moline-based John Deere Family Healthplan stated that the guide is one reference point and that there are many other factors people want to know in making decisions about health plans.

Dr. Jackman said patients would be well served with more information about quality of care. For example, it would be useful to get answers to questions about how patients would be treated if they were diagnosed with cancer. That information is difficult to obtain, she said. "I would hope the HMOs might want to provide more in the future. It's crucial for patients making informed decisions about what plans to choose."

To get information that can help them evaluate quality of care, consumers should ask HMOs directly, according to an ISMS analyst. Plans may be able to provide data on patient satisfaction levels, health outcomes and preventive care, such as child immunization rates.

The HMOs' year-end financial statements provided such information as medical expense ratios, administrative costs,

premium costs and utilization data. For some HMOs, the year-end kitty was bountiful, with the highest pre-tax surplus standing at \$52 million for HMO Illinois. For others, it was barren with 17 HMOs losing at least \$1 million. Of the HMOs that do 30 percent or more of their business in Illinois, John Deere Family Healthplan experienced the deepest loss at \$7.5 million.

Twelve of the 26 HMOs with losses began operation after 1990, and three started in 1996. Harmony Health Plan of Illinois, for example, pointed out that it began enrolling people in September 1996, so the data represents only four months of operation.

Several of the plans noted that information filed with IDOI meets certain government regulations and may not always reflect the total picture of an HMO, so it's a good idea to ask the HMO for details.

Of those plans that do 30 percent or more of their business in Illinois, John Deere spent the greatest percent of income on medical care, 149 percent, or an average of \$5,122 per patient per year. Benchmark Health Insurance ranked No. 2, with 105 percent; and Maxicare Health Plans of the Midwest was next-highest, at 96 percent. One Health Plan of Illinois spent the lowest percent, at 26 percent.

In the amount spent on administration – for instance, salaries, offices, rent and claims processing – the HMOs were all over the map. Administrative costs ranged from a high of \$3.95 for every dollar of income to a low of 5 cents on

What HMOs spent on medical care

Of the HMOs that did 30 percent or more of their business in Illinois in 1996, the following plans spent the highest and lowest percentage of their income on medical care:

Highest	Percent	Avg. expense per member per year
John Deere Family Healthplan	149	\$5,122
Benchmark Health Insurance	105	\$1,250
Maxicare Health Plans of the Midwest	96	\$1,538
Health Alliance Medical Plans	94	\$1,302
Compass Health Care Plans	94	\$1,487

Lowest	Percent	Avg. expense per member per year
One Health Plan of Illinois	26	\$832
Cigna Health Care of St. Louis	68	\$1,120
UIHMO (University of Illinois)	74	\$542
Unity HMO	75	\$1,095
Community Health Plan of Sarah Bush Lincoln	76	\$1,354

the dollar. Guide users can find out the sizes and length of time in operation, with the latter varying from the three that were started in 1996 to the oldest, dating back 21 years.

Of the HMOs doing 30 percent or more of their business in this state, the highest average premium charged per member per year was \$2,121, by Humana Health Plan; the lowest, \$691 by UIHMO, operated by the University of Illinois. The average premium for all Illinois HMOs was \$1,676, calculated by dividing the total premiums by the number of member years.

Premiums are greatly affected by the

types of patients covered in the plan, said the ISMS analyst. In particular, Medicare patients tend to require more services and, accordingly, have higher premiums. UIHMO does not provide coverage to Medicare beneficiaries, but Humana Health Plan has high Medicare enrollment, according to the guide.

The guide is available without charge by writing to ISMS, 20 N. Michigan Ave., Suite 700, Chicago, IL 60602; or by calling (312) 782-1654 or (800) 782-ISMS. The complete guide – including links to definitions, summary tables and other data – is also on the ISMS World Wide Web page at www.isms.org. ■

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Withdrawal of diet

(Continued from page 1)

The distinction will likely depend on who took the appetite suppressants and for how long, Balkin said. The FDA approved fenfluramine and phentermine to be prescribed separately, not in combination, for short-term use by clinically obese patients. So, physicians sticking to that plan are not expected to be sued. But the fen-phen combination became popular because it required lower dosages, and many patients have been taking the combination long term or to help shed a few pounds – usage that doesn't conform to the prescribing criteria.

In general, physicians' roles in pharmaceutical liability cases can take several different forms, said attorney William Rogers, with the Chicago law firm of Bollinger, Ruberry & Garvey. Class-action lawsuits typically name the drug manufacturer, not individual physicians. But sometimes a physician is named with the drug company in individual lawsuits, Rogers said. In these cases, the patient will claim the doctor knew or should have known that the drug was contraindicated or was being prescribed at the wrong dosage.

In other cases, the plaintiffs are strictly after the pharmaceutical manufacturer and ask physicians to testify that if the pharmaceutical company had warned patients, the results might have been different, Rogers said. Patients may also file lawsuits against drug manufacturers, which in turn sue the prescribing physicians, alleging that the usage was off-label. In this type of lawsuit, the pharmaceutical company will argue it met its liability standard when it informed physicians about the drug, Rogers said.

In response to such claims, physicians

may say that manufacturers promoted off-label use through drug reps visiting their offices or that manufacturers knew the drugs were being widely used off-label, Rogers said.

Physicians should inform their patients when there's a development about a drug they've prescribed, according to Rogers. "Morally, it's the right thing to do, and there's a better chance the patient won't sue," he explained, adding that physicians should document any warnings they pass along to patients.

Rogers said physicians should never alter the records of patients taking fen-phen – or any other patients for that matter. "Sometimes, there is a fear that drives physicians to go back and add words like 'I told the patient about the risks of the drug.' That's the worst thing to do."

Physicians should monitor their fen-phen patients for mitral aortic valve damage, said Richard Snodgrass, MD, a Moline cardiovascular specialist. An echocardiogram is the most practical screening tool, he said, adding that it is most important for a patient who has developed new symptoms such as shortness of breath on exertion or a heart murmur.

Edward Langston, MD, a Moline family physician and registered pharmacist, addressed the issue of patients' discontinuation of the drugs. "The vast majority of people won't have side effects [from discontinuation]," he said, adding that in some patients, abrupt withdrawal could lead to a drop in blood pressure or minor cardiac arrhythmia but that most can handle a cold-turkey withdrawal quite well. Although use can be discontinued gradually over a short period, usually about two weeks, some patients may have stockpiled pills and may be tempted to continue taking them, which, of course, they should not do, Dr. Langston said. ■

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PAGE 6

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Practicing
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PAGE 4

Ron Ackerman



ILLINOIS' FIRST LADY Brenda Edgar talks to women lawmakers and physicians about the state's friend-to-friend program promoting education on women's health issues. Her presentation was at the Women's Legislative Dinner sponsored by ISMS and held Oct. 29 in Springfield.

Senators hear pros and cons on ERISA exemptions to state insurance laws

HEARING: Patient protection laws could apply to self-insured plans. BY JANE ZENTMYER

[CHICAGO] Recent federal court rulings have eroded the exemptions from state insurance laws given to self-insured health plans by the Employment Retirement Income Security Act of 1974, said ISMS General Counsel Saul Morse at a hearing held by the Illinois Senate Subcommittee on Managed Care on Oct. 22 in Chicago. This means that if Illinois enacts a patient protection law, as other states have done, it may apply to ERISA plans.

"The courts are moving toward saying that states may provide patient protections and regulate the availability of health and medical services, and the quality of providers of health and medical benefits," Morse said. For example, the U.S. Supreme Court ruled in 1995 that ERISA did not override the state of New York's decision to tax all health plans, including ERISA plans, to pay for indigent care, he said. In its decision, the court noted that "nothing in the language of [ERISA] or the context of its passage indicates that Congress chose to displace general health care regulation, which historically has been a matter of local concern."

In addition, the 7th U.S. Circuit Court of Appeals, which has jurisdiction in Illinois, held that ERISA doesn't completely

pre-empt vicarious liability and ostensible agency claims against managed care organizations and that those claims should generally be tried in state court.

At the hearing, opponents of ERISA reform said that the pre-emption of state laws has allowed employers that operate in more than one state to develop consistent medical plan practices and cost-effective systems and that other court cases have upheld ERISA. "Any effort by the Illinois Legislature to test the boundaries of ERISA pre-emption and impose unique medical plan requirements will be singularly unwelcome," wrote Peter Kelly, a partner with the Chicago law firm Murphy, Smith & Polk, in testimony submitted for the Illinois State Chamber of Commerce. "In time, such legislation will contribute to an image of Illinois as unfriendly to large enterprises."

Morse noted that ERISA plans provide health and welfare benefits to 45 percent to 60 percent of Illinoisans. Although this legal arena is evolving, fed-

(Continued on page 8)



Rep. Mary
Flowers

John McNulty

First Illinois HMO joins Medicare demonstration project

MANAGED CARE: Program will collect information about managed care and payment mechanisms. BY JANE ZENTMYER

[URBANA] The first HMO in the state to participate in the U.S. Health Care Financing Administration's Medicare Choices demonstration project is Premier Choice, which is available through the physician-owned Health Alliance Medical Plans Inc., a subsidiary of Carle Clinic Association in Urbana. Through Medicare Choices, HCFA is gathering information about new types of managed care plans and payment mechanisms, said HCFA spokesperson Paul Cotton. Health Alliance is the 11th managed care entity in the country to join the project and is one of two serving rural areas.

Although Health Alliance entered the Medicare rural market through the demonstration project, other managed care entities that aren't participating in the project may follow into that market, thanks to the 1997 federal Balanced Budget Act, which sets a minimum monthly per-member rate of \$367 for all Medicare HMOs. "That will be a substantial increase in most cases for rural areas," said Chester Stroyny, a former HCFA regional administrator who now owns the consulting firm CCS Consulting Ltd. in Lake Forest. For example, the 1997 rates for Downstate Moultrie, Union and Jo Daviess

counties were \$293.02, \$304 and \$319.14, respectively, according to HCFA.

Medicare Choices gave Health Alliance more favorable rates than it would have received under Medicare's traditional rate structure, which factors into rates the low cost of living in rural areas.

The act also allows providers like physicians and hospitals to form provider-sponsored organizations, which would contract with HCFA to provide services to Medicare beneficiaries and would expand options for Medicare enrollees and create competition for HMOs.

(Continued on page 10)

Insurance parity sought

HEARING: Patients, physicians say severe mental illness deserves the same level of coverage as physical illness. BY LINDA MAE CARLSTONE

[BUFFALO GROVE] Through three decades of chronic depression, Barbara Silvestri has managed to raise a family and hold down a job, but life has definitely not been easy. "I have suffered greatly," she told the Illinois Senate Insurance Subcommittee during its hearing on insurance parity for mental illnesses. Just a year ago, she was hospitalized "in great pain and suicidal."

Silvestri said her hardship hasn't been limited to mental illness. She has also suffered financially because her insurance company pays only 50 percent for her mental illness claims compared with 80 percent for her physical illness claims.

"I have paid the remaining costs out of my pocket for 30 years," Silvestri said. On Oct. 7, she testified in support of H.B. 111, which would require insurers to cover severe mental illnesses under the same terms and conditions that govern coverage for other illnesses and diseases. Parity would apply duration of coverage, payment limits, deductibles and co-insu-

rance requirements. The ISMS-supported measure passed the House earlier this year but remains in committee in the Senate.

The bill, sponsored by Rep. Lauren Beth Gash (D-Deerfield) and Sen. Thomas Walsh (R-Westchester), defines serious mental illness as any mental disorder caused by such factors as biological or physiological disorders of the brain or psychosocial problems that substantially limit activities. Covered illnesses would include schizophrenia, pervasive development disorder, autistic disorders, schizoaffective disorder, delusional disorder, bipolar disorder, major depression, obsessive-compulsive disorder and panic disorder.

More than 100 people at

(Continued on page 8)

INSIDE

Residents
value leadership
award



PAGE 2

IMGs
to share their
views through
IMG section

PAGE 5

DEPARTMENTS

Classifieds9



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MEMBERS OF THE Illinois chapter of the American Association of Retired Persons gather in the rotunda of the Capitol in Springfield for a lobby day devoted to managed care patient rights issues. AARP and ISMS were co-sponsors of the event and support the managed care reforms in H.B. 626.



Ron Ackerman

Residents value leadership award

INVOLVEMENT: AMA award helped winners get involved in organized medicine, but funding has dried up. BY JANE ZENTMYER

[CHICAGO] About this time of year, the AMA has sought entrants for the AMA/Glaxo Wellcome Inc. Leadership Award for almost a decade. This year Glaxo has pulled its funding for the award, but the AMA wants to continue the award program and is looking for a new funding source, according to an AMA spokesperson.

In 1997 the award was given to 40

resident physicians nationwide based on their leadership skills and a strong commitment to patient health and community service. Recipients were given expense-paid trips to attend two AMA House of Delegates meetings to observe AMA policy-making in action.

Illinois resident physicians who won the award last year included Robert Oliver, MD, a third-year resident in internal medicine and pediatrics at Southern Illinois University in Springfield. "Medicine is changing so much right now, and I feel that I need to be involved with organized medicine so I know what's going on," he explained. Dr. Oliver worked on a fund-raiser for a free Springfield community health clinic and encouraged almost 60 residents in Sangamon County to join the AMA Resident Physician Section.

OTHER RECENT WINNERS from Illinois were Anita Chandra-Puri, MD, a pediatrics resident at Northwestern University who participated in a Cabrini-Green public housing youth program and the pediatric clinic at Children's Memorial Hospital; Joilo Barbosa, MD, a fifth-year internal medicine and emergency medicine resident at the University of Illinois-Chicago who served as co-chairman of a committee that developed the first South American Congress on Vegetarian Nutrition and Prevention of Diseases; and Evan David Allen, MD, a neurology resident at Northwestern University who founded the Citywide Clothing Drive Organization, which distributed clothing to families in Chicago housing projects.

Dr. Barbosa said that if he hadn't received the award, he probably wouldn't be involved with the AMA. "When I used to read literature such as AM News and JAMA, I always wondered how these people ended up doing so many things and making a difference," he said. The greatest benefit from participating in organized medicine "is that it's so easy to get involved and get things done. All you need to do is pursue your own interests, and you can make a difference."

Dr. Barbosa's interest in aviation prompted him to develop a resolution, eventually adopted by the AMA House of Delegates, that asked the AMA to urge airlines to update their aircrafts' emergency medical kits. "Anybody who has an idea could end up doing something like that and have a great impact on issues that involve anybody anywhere."

Participation in organized medicine also gives residents the chance to meet other physicians and work on issues important to medicine, award winners said. Dr. Oliver, the Resident Physician Section representative to the ISMS Board of Trustees, said he has worked on the Illinois tort reform effort.

In explaining the importance of the award, AMA immediate past President Daniel Johnson, MD, said, "Our goal is not only to honor medicine's future leaders, but also to encourage them to bring their strengths to bear on the future of our patients and health care system by getting involved in organized medicine." ■



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REPORT for Illinois Physicians

MEDICARE

INFLUENZA AND PNEUMOCOCCAL PNEUMONIA VACCINATIONS

The flu season is here. Please remember to promote the influenza and pneumococcal pneumonia vaccines, which are Medicare-covered preventive health benefits. Research has shown that the administration of these vaccines to Medicare beneficiaries greatly reduces hospital admissions and deaths due to flu, pneumonia, and their complications. Moreover, it has proven that systems-oriented physician and beneficiary interventions work in promoting these vaccinations.

Systems-oriented interventions that increase immunization rates include physician standing orders in hospitals and clinics for both influenza and pneumococcal pneumonia vaccines, distributing pamphlets, and offering the vaccines before hospital discharge. **Although Medicare does not require standing orders for ordering or administering the influenza vaccine, standing orders are required for the pneumococcal vaccine.** The implementation of standing orders in hospitals and clinics is the single intervention most likely to raise vaccination rates. It would be considered a missed opportunity if a beneficiary was discharged from a hospital without being offered (and receiving) vaccination, and later readmitted because of influenza or pneumococcal pneumonia. Therefore, we recommend physicians and nurses promote these vaccinations for Medicare beneficiaries prior to discharge.

Physicians and nurses in outpatient settings can also have a significant role in influencing beneficiaries to be immunized with the influenza vaccine. During the influenza season, physicians can promote these vaccines by placing posters on their office walls as a reminder to themselves and their patients, using chart reminders to track immunized patients, and sending postcards to their patients reminding them about immunization. Physicians can also be instrumental in promoting the pneumococcal vaccine, by applying techniques used for influenza vaccination. Although pneumococcal vaccine is available throughout the year, this vaccine is generally administered once in a lifetime to persons at high-risk of pneumococcal infection. Considered at high risk are persons over age 65, persons who have certain chronic illnesses (e.g., diabetes, cardiovascular or pulmonary disease, alcoholism), and individuals with compromised immune systems (e.g., chronic renal failure, Hodgkins disease, HIV infection). If a high-risk patient is unsure of her or his pneumococcal vaccination status, re-vaccination may be indicated.

Nonparticipating physicians and suppliers are not required to accept assignment when billing Medicare for the influenza virus vaccine and its administration when using standard billing procedures. Entities which undertake mass immunization programs may be eligible to use the "simplified" billing process referred to as roster billing, provided they accept assignment.

Overall, physicians are the most instrumental factor in promoting influenza and pneumococcal pneumonia vaccines. Simply stated, Medicare beneficiaries are most likely to get these vaccines when they believe that their physician wants them to. We ask that physicians recognize this, and promote influenza and pneumococcal vaccinations in their Medicare patient populations.

State strengthens PA prescriptive authority

REVISION: IDPR working on guidelines. BY JANE ZENTMYER

[SPRINGFIELD] While Illinois physician assistants cheered the renewal of the Physician Assistants Practice Act last summer, the biggest change for PAs – the opportunity for supervising physicians to delegate limited prescriptive authority to them – won't go into effect until the Illinois Department of Professional Regulation develops guidelines.

The provision is part of S.B. 372, sponsored by Sen. J. Bradley Burzynski (R-Sycamore) and Rep. Skip Saviano (R-River Grove), and signed by Gov. Jim Edgar in July. According to the law, supervising physicians can delegate prescriptive authority to PAs for Schedule III, IV or V controlled substances. "The key is that the supervising physician still maintains control of the system," said John Lopes, president of the 330-member Illinois Academy of Physician Assistants. "The act includes a provision for the supervising physician [who chooses] not to delegate as well. It's not a mandated blanket delegation."

The law provides a guideline for PAs to use their prescriptive authority. PAs must add their supervising physician's Drug Enforcement Administration number to the appropriate prescription form, which must contain the printed names of both the physician and the PA, and the PA's signature. Supervising physicians must file a written notice with IDPR that explains that they have delegated or terminated a PA's prescriptive authority. Details for these notices will be clarified during rule-making. Supervising physicians are also responsible for periodically reviewing medications prescribed by PAs.

The new law "will make it much easier for patients," said Joan Cummings, MD, chairman of the ISMS Council on Education and Health Workforce. "It will make it quicker for them to get service. It will make it much more reasonable for physicians and their physician assistants to work together without delaying treatment to the patient."

Prescriptive authority will especially help PAs in rural areas, Lopes said. "I work in a rural health clinic, and I'm essentially the sole provider in the whole town. My supervising physician is 15 miles away," said Lopes, who is from Albion. When a patient needs pain-control medication, for example, it's better for the patient if the PA can just write the prescription rather than waiting for the supervising physician to sign it.

The revised Physician Assistants Practice Act also allows one physician to supervise two PAs instead of one physician supervising one PA. This changed ratio may improve health care access for

rural Illinoisans. "One of the physicians in the local area has already hired a second PA," Lopes said. "They have two offices, so this allows him to have full-time coverage in both places." ISMS policy, which was adopted at the 1980 Annual Meeting and revised by the Board of Trustees in 1994, supports the 1:2 ratio.

The law also prevents insurers from denying payment because the patient saw a PA instead of a physician. This

hasn't been an issue in Illinois, Lopes said, but this provision will help ensure that it doesn't become a problem.

Illinois has four PA programs, each of which takes about two years to complete, Lopes said. The first year is spent in classroom study on courses like anatomy and physiology, and the remaining time is spent in clinical clerkships usually in an ambulatory setting.

To be licensed or registered in a state, PAs take a national certifying examination. For recertification, PAs must submit proof of 100 hours of continuing education every two years and take an exam every six years. ■

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EDITORIAL

Practicing lawsuit prevention

After experiencing gastrointestinal problems for several weeks, a 30-year-old woman finally acted on a referral to a gastroenterologist. At his office, she noted on the medical history form that she had recently undergone a myomectomy. As the gastroenterologist began the exam, he noticed the size of her abdominal incision and blurted, "Why did your surgeon cut you like that? He could have made a much smaller incision."

The surgeon in question had explained to the patient before the surgery that because of the size and location of the leiomyoma uteri, he would need to make a longer-than-usual incision. Otherwise, the gastroenterologist, who didn't know the details of the case, might have caused some real problems.

This example illustrates two things: why it's important to communicate with patients, as the surgeon did, and how easy it is to criticize another physician's work. ISMIE's Internal Audit Division analyzed more than 1,000 claims to find out factors – besides bad outcomes – involved in lawsuits against physician policyholders. The analysis found that the second-highest reason was that the subsequent treating physician criticized prior care.

Often physicians have no control over the circumstances that lead to suits. But according to the ISMIE analysis, almost 35 percent of the reviewed cases involved actions or problems that were preventable. Those problems included criticism of prior care, personality conflicts

between physicians and patients and physicians' office workers and patients, and patients' feeling that access to their physicians was restricted or that vital information was withheld.

In studying data on the reasons for claims, the Physician Insurers Association of America found that several problems didn't involve clinical judgment and were avoidable. They included the failure to communicate with a patient, respond properly and supervise or monitor a case.

It's a good idea for physicians to find out the most prevalent clinical and non-clinical causes of claims in their specialty and develop specific standards to prevent them, according to Medical Practice Management. The article cited the success of the American Society of Anesthesiologists in reducing lawsuits by doing just that.

ISMIE has created specialty-specific risk management subcommittees to review closed claims, identify related trends and develop risk management recommendations. In addition, ISMIE offers such risk management resources as brochures, tapes and seminars.

The ISMIE feature in this issue is the first in a three-part series tracking a hypothetical claim through the stages of litigation. Through the series, you'll see that ISMIE offers exceptional support regardless of whether policyholders are working to prevent problems that could lead to lawsuits or going through the litigation process.

PRESIDENT'S LETTER

Why we need strong hospital medical staffs

Jane L. Jackman, MD



With this recent Supreme Court ruling, we need to be active on our hospital medical staffs, attend meetings and speak up for our patients.

On Oct. 23, the Illinois Supreme Court ruled on the legality of hospitals' employing physicians in the case of Richard Berlin Jr. vs. Sarah Bush Lincoln Health Center. In a 5-2 decision, the court reversed the lower courts' decision and held that hospitals may employ physicians, thus ending the uncertainty over whether the ban on the corporate practice of medicine applied to hospitals. The basis for the ban is a doctrine that allows individuals, not corporations, to be licensed to practice medicine, because physicians should be able to exercise independent medical judgment to protect patients from corporations that might put profits ahead of needed medical care. The doctrine has existed since 1923 and is included in Illinois' Medical Practice Act.

A 1936 Illinois Supreme Court decision made it clear that corporations could not legally hire doctors to operate medical practices. However, in recent years the doctrine seems to have been largely ignored. The Illinois Hospital and HealthSystems Association reports that about 7,000 physicians are employed by Illinois hospitals.

The recent ruling eased the way for hospitals to conduct "business as usual" in employing physicians. Although we were disappointed by the ruling, we were pleased that it seems to say that physicians may be employed only by hospitals, not by other corporations or even subsidiaries of hospitals. This should help assure quality health care for our patients.

In arriving at its decision, the Supreme Court looked at policies in other states. It held that public policy and some state statutes authorize hospitals to provide various health care services – for example, emergency services. The court also noted that court decisions have at times held hospitals liable for the actions of their practicing physicians.

A dissenting opinion was written by Justice Moses Harrison and

Justice Benjamin K. Miller, who pointed out that the Legislature is presumed to know about Supreme Court rulings and to consider them in passing new laws. They argued that the passage of the Medical Practice Act in 1997, after the appellate court decision in the Berlin case, was evidence that the Legislature did not want to authorize hospitals to employ physicians and that therefore the court should not make new laws in this area.

Although we are glad that most of the corporate practice of medicine doctrine stands intact – with the exception of hospitals – we need to reinforce our efforts to make sure that doctors who choose to be employed by hospitals can continue to practice as independently as possible. At stake now is doctors' ability to do what they think is in the best interest of patients. Our job is still to be our patients' best advocates, and the Berlin decision does not change that obligation.

Fortunately, our hospitals already have a mechanism to allow this to happen – through participation in a strong, independent medical staff. I appreciate that with our time-consuming patient care responsibilities, many of us are burned out on meetings. Yet, with this recent Supreme Court ruling, we need to be active on our hospital medical staffs, attend meetings and speak up for our patients.

In addition, ISMS and the AMA have strong Organized Medical Staff sections, and I encourage all of you to send your medical staff representative to these meetings. To ensure that hospital medical staffs stay strong and independent, pay attention to your hospital's bylaws, especially to proposed changes. Consider hiring an attorney skilled in these matters to review proposed changes and don't rely on the hospital attorney to represent both the hospital and the medical staff. Your medical staff has been charged with ensuring the quality of care in the hospital. The Berlin decision should make us all more aware of how important a job that is.

GUEST EDITORIAL

IMGs to share their perspective through ISMS section

By Shastri Swaminathan, MD

For the 150,000 international medical graduates in this country, Dec. 9, 1996, was a momentous day. The AMA House of Delegates voted almost unanimously to create an IMG section that has representation in the AMA house. The AMA leadership envisioned this as a way to increase membership and enhance the AMA's communication and interaction with IMGs. Finally IMGs had a forum to express their perspective before the AMA house!

Five months later, IMGs practicing in Illinois celebrated another triumph: The ISMS House of Delegates overwhelmingly approved a resolution to create an IMG section, allowing Illinois to become the third state society to do so.

This progress has evolved slowly. The AMA created the IMG Advisory Committee in 1989 and the IMG caucus in 1992, culminating with the IMG section in 1996. ISMS' action earlier this year is the latest achievement.

The new section could dramatically affect the 10,180 IMGs practicing in Illinois and ISMS. Consider what occurred after the Michigan State Medical Society formed an IMG section: IMG membership increased by 16 percent. With Illinois having the fourth-highest number of IMGs in the United States, there are many potential ISMS members among our ranks.

Clearly, the Society's IMG section will serve as a vehicle for the unique interests of this group. We are concerned with ISMS HOD resolutions that affect us, the problems of deselection by managed care entities and possible discrimination in residency selections. A state medical society can make a difference on these issues. About a year ago, the University of Michigan School of Medicine in Ann Arbor openly refused to allow IMGs to apply to their residency program. The state medical society's IMG section and the society acted quickly, causing the hospital

to retract its position. ISMS' IMG section can become a similarly powerful voice. The section can also foster relationships between IMGs and their

countries of origin to further training and research.

The most convincing argument for the formation of a state IMG section may become an important goal for the group: to promote section members as leaders of ISMS. Twelve years ago, ISMS created the Hospital Medical Staff Section, now called the Organized Medical Staff Section. Many of our ISMS leaders began their Society work in HMSS.

Regarding the structure of Illinois' IMG section, it will probably be similar to that of the AMA. The ISMS IMG section's statement of purpose and bylaws

will be prepared by the ISMS Board of Trustees with input from IMG leadership. This plan will then be submitted for consideration by the ISMS house in April 1998.

The process of creating the Society's IMG section should result in a mechanism for IMG representation in the ISMS house. It will also provide a valuable resource to bring together the many separate ethnic medical societies in Illinois.

Dr. Swaminathan, a Chicago psychiatrist, sponsored the resolution creating the Society's IMG section.

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ISMIE Update

ISMIE extends safety net to policyholders

Follow a physician – and the ISMIE physician-first-service support system – through a medical malpractice lawsuit.

JANE ZENTMYER



Chicago Ob/Gyn Eileen Collins, MD,* was having a hectic but ordinary day. Her reception area and exam rooms were full at 11 a.m., when her office manager interrupted her with a registered letter. That letter turned the day into one that Dr. Collins would never

forget. It said that a patient she had treated for 14 years was suing her for allegedly failing to diagnose breast cancer.

Dr. Collins' first reaction was to call the patient and clarify what had to be a mistake or a misunderstanding. Instead, she remembered that she needed to call her professional liability insurer – the Illinois State Medical Inter-Insurance Exchange. Dr. Collins managed to put aside – at least momentarily – her feelings of anger, betrayal and fear and make the call.

Within the first 48 hours after that call, a defense attorney and a professional liability analyst had been assigned to Dr. Collins' case. Both the attorney and the analyst work in Chicago and were chosen partly because Dr. Collins lives and works in Chicago. When deciding who should be assigned to a case, geographic proximity is a factor. To serve policyholders outside the Chicago area, ISMIE has offices in Springfield, Belleville and Rockford. Each is staffed by professional liability analysts and has working relationships with Downstate defense attorneys.

Within 30 days of notifying ISMIE, Dr. Collins had met with her defense attorney and her analyst for an initial interview about the case. "During the initial interview, we will discuss the medical issues in the case," explained attorney Sheldon Brenner, a partner in Brenner & Moltzen Ltd. in Chicago. "We'll discuss an early defense strategy plan. I'll ask the doctor for his or her input into defense strategy." Physicians are also asked their opinions about any consultants who can be used to review the case and serve as expert witnesses.

An important step in the early stages of litigation is discovery, during which documentation and other material relevant to the case is released to both sides, said attorney Mary Beth Denefe, a partner in Haskell & Perrin in Chicago. Documents include medical records, office logs and billing records. Relevant medical literature is reviewed for any medical information that could help or hurt the case. Attorneys review all this collected information to prepare for the next step, deposition, during which defense and plaintiff attor-

neys get additional information through face-to-face questioning of each other's prospective witnesses.

In Dr. Collins' case, the collected information detailed the care of her patient, 48-year-old Carrie Jessup. Jessup said she felt a lump in her left breast in February 1991, but Dr. Collins didn't find it when she examined Jessup. She instructed Jessup to return in May of that year for her annual exam and to get a mammogram. Jessup delayed getting the mammogram until October 1991 because of an extended family vacation, but despite the delay, the mammogram came back negative. Jessup was nevertheless concerned and returned for a checkup in March 1992, but no masses were found. To get her husband to see an internist in July 1992, Jessup herself scheduled an appointment for an exam. The internist found a mass, which was confirmed through mammography, and a biopsy led to a diagnosis of breast cancer.

Before her deposition, Dr. Collins reviewed the medical records and repeatedly explained to her attorney why she made certain comments and treated Jessup as she did. That preparation is critical to a good deposition, Brenner explained. "Very often if doctors

Resources offer a lifeline to help physician defendants

ISMIE policyholders who've had claims filed against them receive a defense kit at their first meeting with the professional claims analyst and the ISMIE defense attorney. The kit contains pamphlets on such topics as coping with stress, managing your malpractice lawsuit and obtaining defendant reimbursement coverage. Also included is a handbook called "The Physician Defendant," which walks doctors through the litigation process a step at a time.

Physicians can also tap into the Litigation Support Network, whose members

lend a sympathetic ear to physicians who have been sued and their families. Network members do not give legal, insurance or clinical advice, but because they are physicians who have been through the litigation process, they can share their own experiences in surviving the process and suggest resources. All contacts with network volunteers are kept confidential.

For more information about resources, contact ISMIE's Risk Management Division at (800) 782-ISMS or (312) 782-2749.

*Dr. Collins' case is hypothetical.

aren't thoroughly prepared for a deposition, they will simply give bad answers – not on purpose, but because they didn't prepare. Then they'll read their [deposition] transcript before trial and say, 'I can't believe I said that. That's absolutely wrong. You would never use this drug with that condition, because of this side effect. I can't believe I said that.'"

To prepare physicians for deposition, ISMIE defense attorneys outline the questions they plan to ask and try to anticipate questions the plaintiff attorney may ask. Brenner and Denefe said they then meet with the physicians for as long as it takes to get them ready for deposition. Denefe said she also explains which questions require only a yes or no answer and which need a more expansive response. Physicians also get direction on when to look at their charts. "We don't cut corners, because it's just too important," Denefe said.

Throughout the pretrial phase, the ISMIE professional liability analyst regularly contacts the physician and is always available to discuss questions or concerns. The analyst also follows every phase of the case and attends the physician's deposition with him or her.

Dr. Collins took an active role in her defense and attended all the related depositions. ISMIE encourages such participation and offers defendant-reimbursement coverage to reimburse defendants for time spent at depositions other than their own and time spent at trial. Depending on the case, attendance at every deposition may not be necessary, but a physician's presence can help defense attorneys ensure that accurate facts are entered into the official record.

"One of the major reasons I like having the doctor present is that it's harder to be loose with the facts when the person they're talking about is sitting across

the table looking at them," Brenner said. For example, the defendant physician may be able to point out that she was in Europe for a three-week vacation when an alleged conversation took place between the plaintiff and the physician.

Another part of the preliminary process is the decision to settle or defend a case. For ISMIE policyholders, the decision is made by the Physician Review Committee – 27 physicians who represent 21 specialties and a geographic cross-section of Illinois. PRC members have also been sued for medical malpractice.

"PRC members are people who are in the same shoes the defendant is in every day. They take the same risks, have suits filed against them," explained the chairman of the committee. "Having physicians review the case and make decisions is consoling during a difficult and emotional time. You can go to any other insurance company and be evaluated by any insurance [person], but at ISMIE, you're being evaluated by doctors."

PRC reviews between 600 and 700 cases per year, and its decisions are based primarily on the medical facts of the case, the chairman said. The initial recommendation is made by the PRC member who practices in the same specialty as the physician named in the case. The committee then decides whether or not it supports the recommendation. If policyholders disagree with the PRC decision, they can appear before the committee and present new information or explanations. "What we're trying to do is take a case that is medically defensible, defend it and win it," the chairman said.

In Dr. Collins' situation, PRC decided to take the case to trial. ■

Look for the case's second installment in the next issue of Illinois Medicine.



John S. Dykes/SIS

Insurance parity

(Continued from page 1)

tended the hearing at Buffalo Grove City Hall, including representatives from the Coalition to Stop Insurance Redlining of Mental Illness, a grass-roots alliance of patient advocates, family support groups and mental health professionals. Coalition representatives said that insurance policies redline mental illness and prevent patients from regaining their health by denying or restricting coverage for necessary medical treatment.

Mental illness is no different biologically than any physical illness, said Shas-

tri Swaminathan, MD, an Illinois Psychiatric Society council member who specializes in adult and hospital psychiatry and pharmacotherapy. "There is a myth that mental illness is untreatable," he said. On the contrary, the improvement rate is higher than for many other highly specialized conditions typically covered by insurance, he added.

"Mental illness is diagnosable and treatable," yet there is gross discrimination in coverage, said Dr. Swaminathan, who is also a member of ISMS' Council on Mental Health and Addiction and Governmental Affairs Council. According to a study by the U.S. Bureau of

Labor Statistics, 95 percent of employee health plans limit outpatient mental illness coverage, he said. The study also found that 50 percent of these plans limited coverage for hospitalization to 30 to 60 days per year for mental disorders, compared with 120 to unlimited days for physical disorders.

According to the anti-redlining coalition, nondiscriminatory health insurance for the mentally ill can save money by reducing the need for social services and by allowing people with mental illness to work and support themselves.

H.B. 111 opponents argued that mental health coverage parity would dramati-

cally increase premium costs. Representatives of the Illinois State Chamber of Commerce said the bill could increase health care costs for employers and employees by about 8 percent. "By directing employers to provide a specific health care benefit, the state is mandating that employers and employees alike absorb the cost of the benefit, regardless of whether this benefit is meaningful to the group or individual being served," according to testimony submitted by chamber Executive Vice President Jeff Mays. "To comply with this act, individuals and groups buying insurance may be forced to reduce current benefit levels of their health care policies to continue affordable coverage."

An independent study commissioned in 1997 by the National Alliance for the Mentally Ill found many fears about cost did not materialize in New Hampshire after it began requiring insurance coverage for severe mental illnesses to be equal to coverage for other physical illnesses, said Jan Holcomb, executive director of the Mental Health Alliance in Illinois. The 11 health care insurers interviewed for the study said the legislation did not cause them to change premium costs, nor did their insured businesses decrease benefits. "The time for analysis paralysis is over," Holcomb said. "Mental health parity makes good common sense and good economic sense." ■

Senators hear

(Continued from page 1)

eral courts have upheld the application of patient-protection laws to ERISA plans based on the state rights to regulate public health and safety.

In addition to ERISA issues, testimony covered H.B. 626, the ISMS-supported comprehensive managed care reform bill sponsored by Rep. Mary Flowers (D-Chicago) and approved by the Illinois House last spring. Instead of acting on H.B. 626, the subcommittee plans to draft its own version of managed care reform legislation after completing its hearings, said Sen. Thomas Walsh (R-Westchester), the subcommittee chairman.

Gloria Duday, a member of the health care committee of the League of Women Voters in Chicago, said her organization believes the bill would give MCOs the structure needed to improve the quality and cost-effectiveness of health care.

Opponents of managed care reform said that several accreditation groups, such as the National Committee for Quality Assurance and the Joint Commission on the Accreditation of Healthcare Organizations, already ensure that MCOs follow industry standards. "They do a good job with this," said G. Kristin Crosby, MD, national medical director of group health for Intracorp in Pennsylvania. "These regulations would suggest that it would be an excellent framework as you look for appropriate legislation."

Morse countered that NCQA and JCAHO "do not issue regulations. They have no force or effect. They are funded by the companies and entities that adopt those standards. While there is much significance in what they do, compliance is voluntary. They do not have any force in the law, and their standards can be changed with relative ease."

The subcommittee hearing was the fifth and last one planned for the year. "We'll have hearings right into the spring of next year, [when] we may have all the information we need," Walsh said. ■

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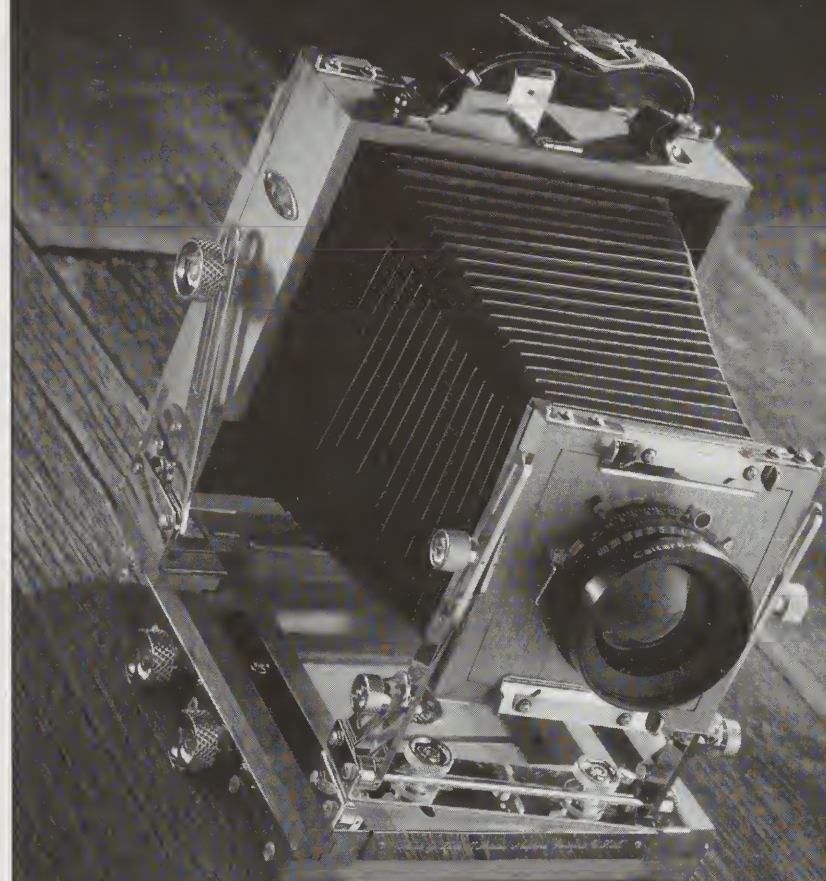
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First Illinois HMO

(Continued from page 1)

As a Medicare HMO, Premier Choice can establish different systems to manage patient care and expand services offered through fee-for-service Medicare. For example, Premier Choice will assess all new enrollees before their first visit with the physician. "If they are low risk, we're going to put a lot of effort into keeping them healthy with wellness initiatives," said Robert Scully, MD, associate medical director for Health Alliance. "If we risk-assess them and they're already high risk – they have multiple medical problems – we will assign them to a team."

That team will include a physician and his or her staff, a physician extender, the patient and the patient's family. With the risk assessment completed, the team can develop a treatment plan to provide optimal care, Dr. Scully said. The plan may also adopt a previous HCFA model in which nurses serve as case managers for high-risk patients, Dr. Scully said. "If the focus is on proactive management of the patient rather than treatment of the illness after the fact, that's a tremendous benefit to these members."

To participate in Premier Choice, Medicare beneficiaries must pay \$25 monthly plus the Part B premium. Additional copayments will be required for some services, such as a \$5 fee for a primary care physician visit. Premier Choice provides the same benefits as Medicare and expands some services, such as offering mammograms and Pap smears annually instead of every other year, said Stacey Robbins, Health Alliance's vice president of business development.

Premier Choice is available to Medicare patients living in most of the counties adjacent to Sangamon, Peoria and Champaign counties. Groups that will provide services to the plan's members include the Springfield Clinic, the Carle Clinic Association and the Methodist Medical Center in Peoria, according to Health Alliance. Patients who enroll in Premier Choice and live outside those service areas can receive care for chronic conditions as long as treatments are preapproved with the primary care physicians, Robbins said. Premier Choice also covers emergency and urgent care for these patients.

Participating physicians have more flexibility in their care for Medicare patients, Robbins said. For example, a fee-for-service Medicare patient who needs skilled nursing care must first be admitted to the hospital for three days, Robbins said. But that rule doesn't apply to Premier Choice. "There are lots of rules and regulations that remove physicians from the overall process. It's as if you have to jump through six hoops if you want to get a patient some care," Robbins said. "This gives us the money up front and allows us to develop the systems to put together a team that will most appropriately manage the patient through our system." ■

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PAGE 3

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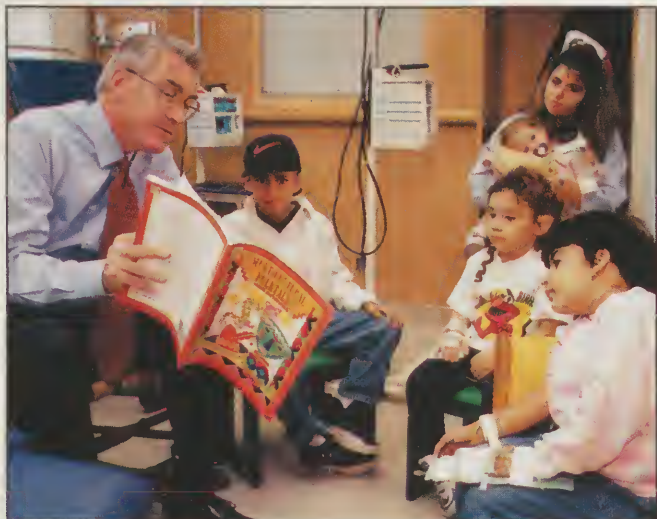
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Child abuse:
opening
Pandora's box

PAGE 8

Matt Ferguson



GOV. JIM EDGAR reads to cancer patients (from left) Jake Ramirez, 8; Emily Glinski, 1, who is on the lap of her mother, Gina; Linda Pacino, 4; and Myra Asghar, 3. The governor visited Children's Memorial Hospital in Chicago during October, after declaring the month Pediatric Cancer Awareness Month.

Balanced Budget Act targets Medicare fraud

NEW LAW: Regulations, details not yet revealed.

BY JANE ZENTMYER

[WASHINGTON] When the expanded provisions of the Health Insurance Portability and Accountability Act became law more than a year ago, federal officials stepped up their efforts to fight Medicare fraud and abuse. This year, Congress added even more anti-fraud and anti-abuse weapons to the federal arsenal with the Balanced Budget Act of 1997, which was signed Aug. 5.

Physicians may be hardened to warnings about Medicare fraud and abuse crack-downs that end up not affecting them very much. But doctors should not dismiss recent changes, according to William Kobler, MD, a member of ISMS' Third Party Payment Processes Committee. "Don't take this lightly," he said. "This is a real growth industry — hiring people to go out and look for fraud and abuse. [The government is] taking this extremely seriously. They've decided that there are billions of dollars to be saved by weeding out Medicare fraud and abuse. While I don't

think there is that amount of money to be saved, they are really looking for this money, and they're going to be very aggressive."

The budget act allows the secretary of the U.S. Department of Health and Human Services to impose civil monetary penalties on physicians who contract with entities or individuals who have been excluded from Medicare programs. The HHS secretary has broad discretion to determine what is in the best interest of Medicare and its beneficiaries. Individuals who have been sanctioned or whose sanctions are imminent cannot transfer ownership or a controlling interest of an entity to a member of their family or household, according to an ISMS analysis.

The federal budget act also carries a "three strikes, you're out" rule for entities or individuals who are considered repeat offenders in the Medicare programs. Those convicted of second offenses must be excluded (Continued on page 14)

Illinois Supreme Court strikes down Petrillo doctrine reforms

[SPRINGFIELD] On Nov. 20 the Illinois Supreme Court ruled 6-0 in Kunkel vs. Walton that reforms made to the Petrillo doctrine are unconstitutional because they violate the separation of powers doctrine and invade plaintiff privacy. Kunkel vs. Walton was the first case challenging the constitutionality of part of H.B. 20 — the comprehensive tort reform bill enacted in 1995 — to be heard by the state's high court.

"The Supreme Court, in this decision, has granted itself a troubling amount of authority over the Legislature elected to represent the people of the state," said ISMS President Jane Jackman, MD. "This decision will help plaintiff attorneys extract nuisance settlements from health care providers by building barriers against an effective defense. That will raise the cost of

LATE NEWS

health care for everyone in Illinois."

"We are disappointed and surprised that the Supreme Court has limited the Legislature's traditional involvement," said ISMS General Counsel Saul Morse.

The Petrillo doctrine tried to protect physician-patient confidentiality by preventing defendant physicians from seeking information about plaintiffs' medical conditions directly from other treating physicians and health care providers. Under the doctrine, the defense must seek that kind of information through the discovery process. In practice, plaintiff attorneys used the doctrine not as a confidentiality shield but as a weapon to prevent the defense from getting information, according

to some defense attorneys.

The 1995 tort reform changes removed the artificial barrier preventing defense attorneys from gathering key information to defend the case. The reforms required plaintiffs to authorize the release of their medical records to defendants within 28 days. If plaintiffs failed to do so, defendants could have requested a court order to obtain the records or have the case dismissed.

The decision in the Kunkel case applies only to changes in the Petrillo doctrine made through the 1995 tort reform law. The Supreme Court has yet to rule in the case of Best vs. Taylor Machine Works Inc., the lawsuit chosen by the court as a vehicle to rule on the constitutionality of the entire law.

Watch the next issue of Illinois Medicine for an analysis of the decision. ■

INSIDE

Case in Point:
hazards of
phoned-in
treatment



PAGE 7

Court ruling
clarifies
physician liens

PAGE 2

DEPARTMENTS

**Malpractice
Roundup.....7**

Classifieds11

**IDPR
Disciplines13**

Hepatitis B debate sparks hearings to review vaccine scheduling

CONTROVERSY: Some parents say the risk that immunization poses for their children is greater than the benefit. BY LINDA MAE CARLSTONE

[CHICAGO] Even though earlier this year, the Illinois Department of Public Health announced a one-year delay in requiring a series of three Hepatitis B vaccines for Illinois youngsters, an advisory group to the department, the Illinois State Board of Health, has begun hearings to review the process used to set immunization schedules for children.

During the first hearing on Oct. 24 in Chicago, several parents and representatives of anti-vaccine groups criticized the

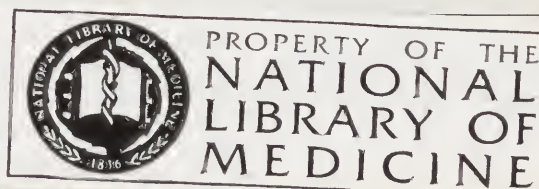
number of required immunizations and testified that some children react to vaccines by becoming ill or even dying. Kathleen Rothschild, a Glenview

mother of two girls, spoke against the addition of the Hepatitis B vaccine to the sched-



James McGee, MD

(Continued on page 14)



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Lien ruling clarifies limits on physician reimbursement

DECISION: Illinois Supreme Court clarifies existing law in favor of physicians. BY JANE ZENTMYER

[SPRINGFIELD] In this era of capitated managed care contracts and shrinking health care budgets, physicians find they need to use every available method to ensure they're adequately compensated for their services. An Illinois Supreme Court decision earlier this

year strengthens one such method available to Illinois physicians through the Physicians Lien Act.

Physicians typically use liens to get reimbursement for services provided to patients involved in personal injury cases like slip-and-falls or car acci-

dents, said ISMS General Counsel Saul Morse. Through liens, physicians can be reimbursed with up to one-third of a case's settlement or judgment. If more than one physician files a lien, the total requested from all physicians cannot exceed one-third of the judgment or settlement.

There are similar provisions in separate lien acts for other health care providers, such as hospitals and dentists.

Morse gave this example: "If a \$30,000 judgment is recovered, up to \$10,000 could go to pay the physician his or her lien. That may not be enough to pay everything the physician is owed,

and the physician can still go against the patient to recover the balance, but this is a way to collect money from the pot of money that may be given out."

But in *Panky Burrell vs. Southern Truss et al.*, a circuit court judge's ruling changed how a lien is calculated. Wood River Township Hospital, Medical Radiological Services Inc. and Anthony Marrese, MD, filed liens in the Saline County Circuit Court seeking reimbursement out of the case's \$8,500 settlement. In his calculations, the judge merged the one hospital and two physician liens so that the final calculation for all health care providers combined would total one-third of the settlement. This was different from keeping the liens separate, so that each type of provider could receive the one-third the lien law allows. The appellate court upheld the lower court decision.

"What happened here is that the physicians filed their liens and the hospital filed its lien, and the court decided that rather than give each one of them what the statute says they're entitled to, it would combine them to determine what the one-third amount was," Morse said.

THE ILLINOIS SUPREME COURT, however, overturned the lower courts' decisions in April. A majority of the justices ruled that the law is clear in this situation: "We believe that the plain language of these statutes limits application of the one-third maximum to each individual act, and [the statutes] require aggregation of only those liens filed under that particular act."

One Supreme Court justice, Moses Harrison II, dissented. "The appellate court correctly noted that if the various liens could be aggregated, as the majority here holds, the total lien could easily consume the plaintiff's entire recovery. The plaintiff would have hired an attorney and endured the rigors of litigation and achieved success and be left with nothing. I share the appellate court's view that the Legislature could not have intended such an absurd and unjust result."

However, during debate on the Home Health Agency Lien Act in the Illinois House, representatives confirmed that if three separate liens were filed under the lien acts for hospitals, physicians and home health agencies, each entity would be entitled to a maximum of one-third of a judgment or settlement. If a \$60,000 judgment was made, each of the three lien categories would receive \$20,000, according to legislators.

Using this legislative exchange and based on the statute's wording, the court concluded that it must follow what the Legislature clearly meant. "To hold otherwise, as [the] plaintiff suggests, would require us to read into the statutes an additional limitation that the Legislature did not include," the court wrote.

The significance to physicians is that "with some frequency, at least anecdotally, physicians have filed these liens, and they're either never notified that there's been a settlement or judgment, or when the time comes around, they don't get the full amount," Morse said. Many physicians haven't fought such actions, but the Supreme Court's decision provides interpretation that the lower courts are bound to follow. ■



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REPORT for Illinois Physicians

"GAG CLAUSES" AND MANAGED CARE

"Gag clauses" in managed care contracts have been a popular topic in the lay press over recent months. A gag clause is defined as a contract provision which restricts physicians from discussing all appropriate medical decisions with their patients.

It has been debated whether the gag clause controversy is one of perception rather than reality — a problem which doesn't exist. A 1997 General Accounting Office (GAO) report, following a review of 529 HMOs, claims this type of restrictive language appeared in none of the contracts. Opponents argue that such clauses do exist, but they are being successfully abolished through state legislation banning such provisions. To date, over thirty states have adopted anti-gag laws. Regardless of the scope of the problem, there is essentially no disagreement that gag clauses are inappropriate and ultimately harmful to patients.

Congress has already acted to ban gag clauses in contracts by managed care plans serving Medicare and Medicaid patients, and there is a gaining momentum to enact anti-gag legislation directed at commercial plans. At BlueCross and BlueShield of Illinois, no such language exists or has ever existed in any contracts. Like other health plans, BCBSI takes seriously its obligation to facilitate the physician-patient relationship, thereby permitting members access to quality health care.

A candid physician-patient discussion regarding treatment alternatives is an essential element of informed consent. The HMOs of BlueCross BlueShield of Illinois have long-standing policies related to member rights and responsibilities, specifically advising members of their right to be completely informed about their diagnosis, treatment and prognosis, as well as their right to participate in decisions involving their care. As it has been in the past, communication of the full scope of treatment options will continue to remain the responsibility of the attending physician.

State Medicaid drug manual uses physician input

IDPA: Drugs that aren't included in the manual may be prescribed, but they require prior approval. BY LINDA MAE CARLSTONE

[SPRINGFIELD] Drug formularies with complicated approval systems may cause problems for some physicians and patients, but that's really not the case with Medicaid's prior-approval process. If physicians understand the process of getting approval to prescribe medications that aren't listed in the Illinois Department of Public Aid's drug manual, they should experience few if any hassles, said Marshall Blankenship, MD, chairman of ISMS' Committee on Drugs and Therapeutics. Only drugs that aren't listed in the IDPA drug manual require prior approval, Dr. Blankenship said.

Requests for a drug that requires prior approval can be made by calling, faxing or writing to IDPA, according to John Cribbett, supervisor of the IDPA prior-approval program. By federal law the department must respond to requests within 24 hours. After working hours, an automated system is available to take requests. If there's an emergency when the IDPA office is closed, physicians may prescribe a 72-hour supply of an unapproved drug.

IDPA pharmacists review about 2,000 prior-approval requests per day, and the vast majority are approved; only about 7 percent are denied because they don't meet the requirements, according to Cribbett. In making requests, physicians must justify why medications in the drug manual won't do the job, Cribbett said.

All requests should include the patient's full name and Medicaid identification number, the physician's name and Medicaid provider identification number, the diagnosis or medical need and, if applicable, other drug regimens previously tried for the same condition. "The more information a doctor can give us, the quicker we can process the request," Cribbett said.

In determining which drugs will be included in the drug manual, IDPA relies on advice from ISMS' Committee on Drugs and Therapeutics, which meets regularly to consider whether new FDA-approved drugs should require prior approval. The committee looks at how useful the drug is and whether it meets different medical needs than the drugs already listed, said Joseph Perez, MD, a member and former chairman of the ISMS committee. The committee also considers patient compliance, dosing, potential side effects and the availability of other drugs.

The committee's recommendations are sent to the ISMS Board of Trustees for approval before being forwarded to IDPA. ISMS' recommendations are not binding; IDPA must consider the bud-

getary impact and such factors as whether the drug could prevent a higher level of care like hospitalization.

The system works well, but it does have some limitations. For example, IDPA recognizes that antihistamines could be used as cough and cold preparations. So, physicians who see patients with allergy problems, for instance, must get prior approval to prescribe antihistamines.

Because antihistamines are so widely used for allergies, allergists who prescribe them a lot have to get a lot of prior approvals, according to C. Lucy Park, MD, the former president of the Illinois Society of Allergy and Immunology. That poses administrative problems. "Many physicians [have offices that are] short-staffed and don't have the time to call Springfield for prior approval. And sometimes the line is busy."

If physicians can justify that antihistamines are being prescribed to treat allergies or other medical conditions, not colds, IDPA usually approves them, Cribbett said.

To ask for prior approval, physicians may call IDPA at (800) 252-8942 or (217) 782-5565, fax requests to (217) 524-7194, or write to the IDPA Drug Unit - Prior Approval, P.O. Box 19117, Springfield, IL 62794.

The Committee on Drug and Therapeutics is continuing to work with IDPA to improve the prior-approval process. Physicians who have questions about the drug-selection process may call ISMS' Health Care Finance Division at (312) 782-1654 or (800) 782-ISMS or write to ISMS' Committee on Drugs and Therapeutics, 20 N. Michigan Ave., Suite 700, Chicago, IL 60602. ■

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EDITORIAL

We need to support free clinics

One of the disadvantages of welfare reform is that it may increase the number of uninsured Americans. That number is already at about 45 million, according to the National Free Clinic Foundation of America. The federal Health Insurance Portability and Accountability Act has helped improve insurance portability and access, but it hasn't been a panacea. One of the most practical ways to treat the uninsured is still through free clinics.

With 23 free clinics in operation, Illinois ranks among the top five states with the most free clinics. Although the clinics reflect the particular needs of their communities, they all have some things in common: They provide services at little or no charge to patients and have an independent governing body and a varied base of community support. That support should come not only from the individuals who volunteer but also from organizations that give generously. A health insurer in Virginia, for example, donates funds to all the state's free clinics to help reduce overutilization of hospital emergency departments and the related costs. Hospitals could work toward the same goal by supporting a free clinic in their community.

For physicians, even the prospect of committing to volunteer at a free clinic may cause some angst. Doctors are already dealing with a lot – inconsistencies

among the managed care plans they work with, increasing demands for documentation and the conflicting emphasis on clinical outcomes and financial accountability, to name a few. In addition, the way physicians practice today – with offices in several locations – isn't always compatible with a sense of community.

Although many physicians provide at least some free care in their own practices, wouldn't it be refreshing to practice medicine in a setting where you weren't pressured to see a certain number of patients per hour? According to some of the people who have founded free clinics, medical staffing in free clinics would be sufficient if every physician in the community agreed to work at the clinic for just half a day once a year.

ISMS supports the delivery of care through free clinics and backed state legislation that protects physicians from liability related to care provided without reimbursement at such clinics.

In Illinois, free clinics have been started by following the example of existing clinics. That concept was behind the development of the Free Clinic Foundation of America, which can be reached at (540) 344-8242.

To find a free clinic near you, call the Illinois Free Clinic Network at (847) 360-8800 or watch for the names and phone numbers of all 23 clinics in an upcoming issue of Illinois Medicine.

PRESIDENT'S LETTER

A strong AMA benefits us all

Jane L. Jackman, MD



Now, more than ever, we need the AMA to be a strong advocate for the working doctors of our country and the patients they treat.

When the AMA's House of Delegates convenes this month in Dallas, no doubt the "Sunbeam deal" will be hotly debated. Many members have been angered by the proposed exclusive contract the AMA made with Sunbeam Corp., which broke a long-standing AMA policy against product endorsements. Critics viewed the contract as a means for the AMA to add to its bottom line rather than to carry on its tradition of advancing the art and science of medicine.

There is no doubt that the AMA has been publicly held to a higher standard of ethics than other organizations that endorse commercial products, and perhaps that is justified. After all, as the nation's largest doctor organization, the AMA has voiced concerns about the "industrialization" of our profession and the worrisome emphasis on "bottom-line" medicine that is so prevalent. At the very least, the details of the Sunbeam deal have caused doctors some public discomfort and embarrassment.

In response to its critics, the AMA has called for a full investigation to find out how this transaction occurred without the knowledge of the Board of Trustees. Recently, three top executives were asked to resign and the AMA's chief attorney quit after being relieved of some of his duties.

Despite these actions, several state medical societies, including ISMS, are asking for a full, independent investigation of the Sunbeam contract and a promise that no more exclusive product endorsements will be allowed. The ISMS Board of Trustees took this position after hearing a number of member complaints about the AMA's action. Our aim is to find out more about what actually happened so that steps can be taken to ensure that this type of mistake will not happen again.

Certainly, beating the AMA over the head is no fun, especially because the AMA is you and I. Our hope is that by taking an open,

honest look at the facts, the AMA will become a stronger organization. We need to do all we can to help restore the respect and trust that the public, Congress and member doctors have had in the AMA. In large part, organized medicine exists to uphold the ethics and dignity of our profession.

Maybe we need to look again at why organized medicine, especially the AMA, exists. Most of us probably belong to specialty societies as well as ISMS and the AMA. Our specialty societies, however, of necessity, have a narrower focus than ISMS and the AMA. Because of this, the specialty societies are often in conflict with one another, especially over turf and pocketbook issues. To the public and our legislators, that can be confusing.

Because the AMA includes representatives from all our specialty societies, there is a spirit of cooperation between primary care and specialties. The AMA provides a place for different specialties to have dialogues with one another and reach a consensus about what is best for our patients. In Washington, the AMA is still really the only game in town. It is still the largest and most influential medical body in the world. It still has more influence with the public and business than any other medical organization.

Now, more than any other time in our history, we need to stand united as a profession. Divided, we will be conquered and controlled by those wanting to profit from our hard work and compassion for our patients. Now, more than ever, we need the AMA to be a strong advocate for the working doctors of our country and the patients they treat. The doctor-patient relationship is under attack with the growth of managed care, and our ethical principles are at stake with the possibility that physician-assisted suicide may become law. What is needed is a national organization of doctors to place patients' concerns above governmental or business pressures and to preserve the integrity of the medical profession. That organization is the AMA.

GUEST EDITORIAL

Why we came back to ISMIE

By Stephen Minore, MD

Making a decision to switch malpractice insurers is not easy, nor should it be. When it's time to renew, regardless of how we feel about our current insurer, our group of 39 board-certified anesthesiologists evaluates three to five companies. First, we look at the ratings. Then, we consider the financial reports, reserves, claims histories and payment histories. Finally, we talk to other physicians who've had claims filed against them and who've been defended by those insurers.

Two years ago, we made a difficult decision. We had been with ISMIE for more than 21 years, were happy with its services and knew that its BBB Standard and Poor's rating and B+ A.M. Best rating were solid. But our research suggested that we could find comparable coverage for less money, so we chose another insurer.

At first, we were pleased with our decision. But after we had been through some claims, we found that the support, communication and responsiveness were not as good as they had been with ISMIE. With the new insurer, there always seemed to be some delay. When we asked for certificates of insurance, for

example, there was always some reason we couldn't get them when we needed them.

We never experienced those delays with ISMIE. When we called, we always felt as if we were at the top of the company's priority list. The ISMIE regional claims coordinator for our area always kept us informed about the status of our claims. She told us about physician depositions, helped us schedule them at convenient times and proved she had a strong working knowledge of medical malpractice and the legal system.

It was also important to us that ISMIE didn't force us to settle a case if we wanted to fight it and if ISMIE's Physician Review Committee, made up of physicians, thought it was defensible.

So, this year, when it was again time to renew our coverage, we remembered the service that ISMIE had provided. We also realized that because ISMIE is operated by physicians, the company is doctor-friendly. That is reflected in the way rates are set. Other insurers may fail to recognize that with relatively few lawsuits and minor settlements, we should not be charged as if we had had major, repeated losses. But ISMIE rewards

Dates for Annual Meeting, resolution deadline set

Mark your 1998 calendar: The ISMS House of Delegates Annual Meeting will be held April 24-26 at the Oak Brook Hills Hotel at 3500 Midwest Road in Oak Brook.

County medical societies should send a list of delegates and alternates to ISMS headquarters before Jan. 31. All delegates and alternates will be notified of the meeting through an official meeting call.

Only delegates and voting members of the House of Delegates may submit resolutions. Resolutions must be received at ISMS headquarters before the close of business on March 24; a March 24 postmark is not sufficient. After that date, resolutions will be considered late and will be

reviewed by the Committee on Rules and Order of Business to determine whether the house should consider them.

Resolutions should be addressed to Speaker of the House of Delegates John Schneider, MD, Illinois State Medical Society, 20 N. Michigan Ave., Suite 700, Chicago, IL 60602. The ISMIE Annual Meeting is scheduled for April 22 at the Oak Brook Hills Hotel.

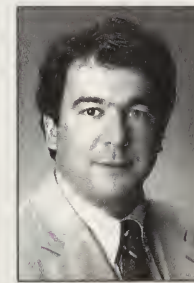
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Dr. Minore is president of Rockford Anesthesiologists Associated in Rockford.

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Case in Point

PAGE 7

ISMIE
Update

ISMIE policyholder gets her day in court

Familiarity with the facts of the case and thorough preparation are critical to sound testimony.

BY JANE ZENTMYER

After what seemed like an eternity but was in reality four years, the case of Eileen Collins, MD, a Chicago Ob/Gyn,* finally went to trial. Dr. Collins had been sued for malpractice by a long-time patient, Carrie Jessup, who claimed the physician had failed to diagnose breast cancer in a timely manner. Dr. Collins arrived at trial feeling nervous about her upcoming time in court. Her ISMIE defense attorney, Howard Buchman, had given her some idea about what to expect, but she was apprehensive about facing her former patient and the plaintiff attorney, Richard Frazier, who she knew would question her skill and attack her judgment.

Knowing that the jury would be watching and judging her, Dr. Collins had carefully chosen her outfit – a simple, dark blue business suit – and decided against wearing jewelry or other accessories. Her choice was a good one. “The only thing the jury should be concentrating on is evidence,” said Sheldon Brenner, a partner with the law firm Brenner & Moltzen Ltd. in Chicago. “There should be no reason the jury has to think about a person’s appearance. I tell my clients to dress tastefully and conservatively so that there’s nothing about what they’re wearing that would distract the jury.”

Dr. Collins had also taken time off from her practice so that she could attend the whole trial, including both sides’ presentation of their case and the jury’s announcement of its decision. A physician’s attendance is crucial for two reasons, said Mary Beth Denefe, a partner with the law firm Haskell & Perrin in Chicago. “You want the jury to see that you have a doctor who is concerned and interested in the case. And the attorney may need input from



Jeff Cadge/Image Bank

the doctor.”

Fortunately for Dr. Collins, ISMIE provides defendant reimbursement coverage to help defray loss of income from time spent away from the practice. Early on, ISMIE had also assigned Dr. Collins’ case to a professional liability analyst to help answer any questions or address any concerns. That help had become invaluable as the case progressed, and Dr. Collins was reassured to know the analyst would be in the courtroom during her testimony.

With the jury selection process already completed, the trial began at 9 a.m. with plaintiff attorney Frazier’s opening statement. Frazier outlined his case and explained the supporting evidence that would be introduced. Then, it was defense attorney Buchman’s turn to present his opening

statement. After both sides finished, the trial focused on the presentation of evidence.

Medical records and other information collected during discovery and deposition outlined the facts of the case: Jessup saw Dr. Collins in February 1991 complaining of a lump in her left breast, but Dr. Collins didn’t identify a mass during the examination. She instructed Jessup to return in May for her annual exam and a mammogram. Jessup had the exam but delayed the mammogram until October 1991. Despite the delay, the mammogram came back negative. Jessup remained concerned about the possibility of a lump, though, and in March 1992, she returned for a checkup, but still no masses were found.

To encourage her husband to see an internist four months lat-

er, Jessup scheduled an appointment for herself. The internist found a mass and an elevated platelet count. The radiologist reported that the mammogram showed a large group of suspicious calcifications in the left upper outer quadrant, and he believed the calcifications suggested malignancy.

Jessup was referred to a surgeon, who performed a needle biopsy. The pathologist’s interpretation was ductal carcinoma of the left breast. Jessup was immediately scheduled for surgery, and her surgeon performed a modified radical mastectomy. After the surgery, Jessup underwent a three-month course of high-dose chemotherapy.

A year and a half after Jessup filed suit against Dr. Collins, a mass was found on the right lobe of the thyroid in the lower

pole, but a biopsy was negative.

As part of the interpretation of evidence, expert witnesses for both sides offered conflicting opinions about what the expected standard of care was and whether Dr. Collins met it. Although expert testimony is important, it doesn’t usually make or break the case, according to defense attorneys. “I could hire the best expert in the country, but he’s always someone we’ve paid to come to court. The plaintiff does the same thing,” Brenner said. “In many trials, experts may negate one another, and the case comes down to whether the jury believes and trusts the doctor defendant.”

To ensure that the jury would get an accurate impression of Dr. Collins’ expertise, Frazier met with her many times, preparing her for the

* Dr. Collins’ case is hypothetical.

witness stand. He anticipated the questions that Buchman would ask and quizzed her on them. Frazier also drilled her on the questions he would ask her. Dr. Collins reviewed all the medical records, studied relevant literature and worked on presenting information in a way that nonmedical jurors would understand.

With all the preparation behind her, Dr. Collins knew she was ready when she took the stand several weeks into the trial. That preparation paid off, because she managed to control her emotions when Buchman asked such questions as, "When you wrote 'breasts negative,' you didn't mean that she didn't have breasts and you didn't mean that she didn't have fibrocystic disease. Didn't you mean that there was nothing that there caused you to be suspicious?" and "Where in your records did you state that my client agreed that the breast was stable?"

Although she was nervous, Dr. Collins was somewhat relieved when she finally got the chance to tell her side by answering Frazier's questions. She explained that Jessup had no family history of breast cancer but did have a history of fibrocystic disease, which can cause lumpiness in the breasts. When Jessup returned for an exam in May, she no longer complained of the lump and agreed with Dr. Collins that the breast was stable. The October 1991 mammogram results offered further reassurance, Dr. Collins said.

When Jessup was questioned by Buchman, her version of the events was quite different. She said that she disagreed with Dr. Collins' finding that the lump wasn't there and that she had said so during the exam. "It was still there, but I felt stupid because nobody else could feel it or find it except me," Jessup said. This lump was different from others she had noticed over the years, she noted.

But on cross-examination, Frazier pointed out that Jessup had changed her story since her deposition. Previously, Jessup had said that she couldn't find the lump during the May 1991 exam and agreed with Dr. Collins' assessment that the breast was stable.



Once the jury heard the evidence and closing arguments from Frazier and Buchman, it left the courtroom to deliberate. The length of time the jury needs to reach its decision has little impact on the fate of the defendant. "Verdicts in Illinois have to be unanimous," Brenner said. "The jury could be 11-1 in your favor in 15 minutes. But if one juror refuses to vote for you, the jury could deliberate for eight hours until that person is finally convinced that he or she is wrong."

When the jury returned, it held that Dr. Collins acted within the standard of care and did not fail to diagnose breast cancer in a timely manner. ■

Watch for the final segment in this series to find out what happened after the trial.

Suicidal patient needed more than phoned-in treatment

BY LINDA MAE CARLSTONE

Jack Barton was only 50 but suffered from diabetes, liver disease, pancreatitis and cancer. His pain had become so unbearable and his prognosis was so poor that he decided to commit suicide by overdosing on insulin.

After taking the overdose, he ended up at the emergency department, where intervention quickly brought him out of a coma. He was able to leave the hospital in less than 12 hours. But within seven hours of his discharge, Barton died at home, and the people who saved his life the night before were blamed for his death.

The case in brief: Barton arrived unconscious at the emergency department of a small Downstate hospital at 7 p.m. on a Friday. He was accompanied by his sister, with whom he had been living. She told the nurse that she suspected her brother had decided to end his suffering and taken an intentional overdose.

No physician was on duty at the emergency department, so the nurse telephoned on-call physician James Sutton, MD, and reported Barton's arrival and the below-normal glucose reading of 20. Following the physician's orders, the nurse administered Dextrose, which revived the patient.

Dr. Sutton also directed the nurse to call mental health authorities about Barton's suicide attempt and not to release the patient until those authorities believed that doing so was safe. He also told the nurse to call the local poison control center and document the effects of the overdose. Each order was conducted by telephone, and the physician never saw the patient.

At 5 a.m. the next day, Barton's lab test results were below average: His glucose level was 23, with normal being 70-110; his potassium was 2.7, with normal being 3.6-5.2; his creatinine was 0.7, with normal being 0.8-1.3; his sodium was 139, with normal being 140-148; and his chloride was 97, with normal being 100-108. Dr. Sutton was not informed of these results.

The nurse called Dr. Sutton at 6 a.m. to report that mental health workers had seen Barton and said he could be discharged. At noon that day, an ambulance crew found Barton unresponsive at his home, and he was pronounced dead an hour later. The cause of death was listed as cancer, but no autopsy was performed.



Barton's family sued the hospital and Dr. Sutton, alleging negligence because of failure to properly evaluate and monitor the patient. During discovery, Dr. Sutton admitted that he had failed to document his telephone orders, and during his deposition, he had to rely on his memory of the content of those conversations. He was unable to remember the nurse's name.

The points this case makes: This patient should have been evaluated in person by a physician and admitted to the hospital for observation, according to legal and medical experts. Treating patients using only the

Once a doctor enters orders, he or she has taken management of the patient.

telephone is always risky, but when a patient is burdened with extreme mental and physical problems like Barton's, it is downright wrong, said Alec Hood, MD, a McLeansboro surgeon who is an on-call emergency department physician. Minor conditions like toothaches may be treatable over the phone, but it's never appropriate to skip an examination if a patient seems medically or emotionally unstable, Dr. Hood said. It's better to err on the side of caution, he noted.

A suicidal patient should always be admitted and evaluated, agreed Scott Cooper, MD, an emergency department physician at St. Francis Family Health Center in Blue Island. Because Barton was in the emergency department for more than 10 hours, Dr. Sutton had plenty of time to work a visit into his schedule, Dr. Cooper said. "He couldn't say he was in surgery and not available to get over there."

Emergency department misuse can skew physicians' ability to judge when they should drive in to examine a patient, Dr. Hood said. "Up to half the people who come to the ER are not facing true emergencies. But

once patients show up in the ER, they are covered by the same regulations as if they have had a heart attack or were in a car accident. Many times it's easier to go to the hospital to handle a totally nonsensical problem."

From a legal standpoint, Dr. Sutton was responsible for the patient even though he didn't see him in person, said Dave Burtker, an attorney with the Chicago law firm French, Kazelis & Kominirek. "Once a doctor enters orders, he or she has taken management of the patient," he said.

Dr. Sutton's decision to hand over the patient's care to mental health authorities was inappropriate, Burtker said. "He shirked his medical responsibility. Anyone who tries to commit suicide should be a candidate for psychological consultation." In court, a plaintiff attorney would remind the jury that the patient attempted suicide before he got to the hospital, he said.

Burtker said most hospitals' protocols would call for the physician in such cases to examine the patient and not rely on a phoned-in diagnosis. "The circumstances would be different if a physician were on duty, if there had been physician-to-patient communication. But no physician ever touched the guy."

Dr. Sutton also should have asked about lab test results even if no one volunteered the information. With problems as severe as Barton's, the physician should have ordered the tests or at least anticipated that they'd be taken, Dr. Cooper said. If Dr. Sutton had gone to the hospital, he would have seen the records for himself, Dr. Cooper added.

Another problem for Dr. Sutton was his lack of documentation to support his testimony. "A physician should log every communication — conversations with a nurse or with the patient's family, even conversations held at 3 in the morning," Dr. Cooper stressed. "The purpose of the log is to prove the conversation existed and at what time." Physicians feel they don't have the time to record every action, but this simple task can be crucial in a lawsuit, he said. "I do all my notes with a laptop [computer], but doctors can always jot notes in a pocket-sized log book that they can carry everywhere," he said. ■

"Case in Point" uses hypothetical case histories to illustrate risk management maxims.

MALPRACTICE ROUNDUP

Physician provided enough information about hernia operation, jury rules

A California jury found that a physician did not fail to disclose information to enable a patient to make an informed decision about a laparoscopic hernia repair, according to the October issue of Medical Malpractice Law & Strategy.

In *Abbott vs. Mandiola*, the patient suffered from extreme groin pain for six months after his surgery and reinjured himself while moving a heavy appliance at his job. The plaintiff attorneys claimed the physician failed to tell the patient that three of seven previous patients experienced postoperative complications from this operation.

The patient alleged that the physician surgically stapled the genito-femoral nerve, which was stretched when the patient moved the appliance, causing nerve damage and further pain. The hernia, however, did not recur.

The physician responded that informed consent was adequate, that the nerve injury was probably caused by scar tissue and that other symptoms may have resulted from an injury caused by the patient's moving the appliance.

When physicians confront the issue of child abuse and neglect, they may fear they're opening Pandora's box. To some extent, they are.

On one hand, a child may present with relatively minor symptoms, mere physical clues that point to previously unrecognized mistreatment and a family buckling under the stress of impoverishment or substance abuse. On the other hand, what looks like an intentional injury might simply have been caused by an accidental tumble.

"This is a tough issue for physicians," said Jane Joost, MD, a developmental and behavioral pediatrician and assistant professor of pediatrics at Southern Illinois University School of Medicine in Springfield. "There are a lot of gray areas when it comes to identifying child abuse and neglect."

rarely consistent when they talk about sexual abuse that has occurred.

Neglect can be an equally murky area. What looks like neglect or disinterest by the mother, for example, may actually be symptoms of her clinical depression. "Poverty may be another confounder for neglect. Families may actually be too impoverished to fully care for their children," Dr. Joost added. However, abuse and neglect – physical, emotional or sexual – can occur in families from any economic or cultural background, she noted.

How, then, can physicians accurately determine whether a child has been abused or neglected? Exercising good clinical judgment is the cornerstone, LeBlang said.

If a child presents with a questionable injury, for example, the physician needs to decide whether the

Child abuse: opening Pandora

Physicians may fear making mistakes when they try to identify abuse or neglect.

BY KAREN TITUS

What is clear, however, is that state law requires physicians to report their suspicions to the Illinois Department of Children and Family Services. Physicians are among a group of professionals designated as mandatory reporters under Illinois' Abused and Neglected Child Reporting Act. As such, physicians are legally obligated to contact DCFS when they have a reasonable belief that abuse or neglect has occurred.

"The law is specific," said attorney Theodore LeBlang, professor of medical jurisprudence and chairman of the medical humanities department at the SIU School of Medicine. "It says the standard or threshold for reporting is a 'reasonable' belief that a child known to [physicians] as professionals may be an abused or a neglected child. That adjective is important. The physician does not have to have absolute certainty that abuse or neglect has occurred in order to make a report."

That point is critical, according to experts. Even the best-trained physicians may find it difficult to prove abuse or neglect, said Dr. Joost, who, along with LeBlang, teaches a two-hour seminar on legal and clinical aspects of child abuse and neglect to SIU medical students in the pediatrics clerkship.

"Many of the characteristics of abuse are not clear-cut," Dr. Joost said. "The findings are often subtle, and they may be behavioral characteristics rather than a physical injury. If you see a kid with chronic constipation, for example, or with a sleep disturbance that wasn't previously there, you have to ask yourself if [abuse] is a possibility. Sometimes that's how kids manifest abuse." Children traumatized by abuse or neglect may also be inattentive in school and subsequently be misdiagnosed as having attention deficit disorder, although the real culprit is post-traumatic stress disorder.

Physicians may find it equally difficult to identify sexual or emotional abuse, Dr. Joost continued. Emotional abuse doesn't lend itself to easy identification because of a lack of physical evidence, she said, and sexual abuse is hard to pin down because children are

parent's or caregiver's explanation or history of the injury is consistent with the injury. "It's important to match the physical injury with the story," Dr. Joost said. "If you see an infant or child who is too young to walk coming in with bruising in any location, that should raise a warning flag."

Burns are involved in many abuse cases, LeBlang said. If tap water burns occur in what appears to be an immersion pattern, as opposed to splashes, "it's probably not accidental." Physicians also need to be alert about fracture locations. Fractured collarbones may be common and accidental in children, but spiral fractures generally are not, LeBlang said.



The physician does not have to have absolute certainty that abuse or neglect has occurred in order to make a report.

Ultimately, LeBlang noted, physicians must make determinations case by case. But the decision doesn't have to rest solely with them. Edward Cotton, deputy director of the DCFS Division of Child Protection, said, "There is nothing in the law that says doctors have to prove abuse or neglect. That's our job."

"Our hotline gets 1,400 calls a day," he continued, "so our investigators are pretty good at sifting through the details and understanding kids' motivations and determining whether abuse or neglect has occurred."

To trigger the screening process, though, the physician needs to report a suspected problem by calling the hotline, (800) 25-ABUSE, which is operational 24 hours a day, every day of the year. The hotline worker will ask a series of questions to determine whether an

a's box



Jan Stamm

investigation is warranted, Cotton said. If so, an investigation will begin within 24 hours, although in emergencies, investigators will meet with a child in as little as 10 minutes.

In rare cases, physicians may be called on to take the child into protective custody, Cotton said. If a child appears to be in immediate danger, Illinois law gives the authority to assume protective custody to DCFS, police and physicians, but DCFS usually acts on that authority, Cotton said.

Once a case has been opened, physicians are legally obligated to participate in the investigation. Physicians may be interviewed by investigators and asked for copies of medical records and to testify at subsequent hearings or trials.

Regarding liability involved in mandated reporting, the law provides wide protections, LeBlang said. "Under Illinois law, when a physician reports suspected abuse or neglect, he or she has good faith immunity from any kind of liability – civil, criminal or otherwise. Physicians enjoy an extremely powerful legal immunity. They must act in good faith when they make a report, but good faith is presumed."

Overtaking that presumption of good faith "would be very, very difficult to achieve in a court of law, where you have a presumption of good faith, a medical record that reflects a reasonable history and a physical exam supporting the physician's conclusion that the child may have been subject to abuse or neglect," LeBlang continued. "I'm aware of no case in Illinois where that presumption has been overcome."

However, willful failure to report suspected abuse or neglect would cause the incident to be reported to the Illinois Department of Professional Regulation's Medical Disciplinary Board, according to LeBlang. "It

could result in an array of disciplinary measures, up to and including suspension or revocation of a license." Furthermore, he said, California case law indicates that physicians may be subject to malpractice lawsuits if they fail to report abuse or neglect and the child is later injured more severely.

Under Illinois' reporting act, the standard rules of physician-patient confidentiality are waived, with the medical records and interactions between physician, patient and parents no longer viewed as confidential, LeBlang explained.

If someone other than a physician initiates an investigation and the case appears to have a clinical component, DCFS generally tries to obtain the medical records. In such cases, DCFS would first ask the parents to release the records, Cotton said. Failing that, the department can issue an administrative subpoena to obtain the records from the physician, according to Cotton.

Complying with a subpoena may be viewed as participating in the investigation, in which case the physician would have full immunity, LeBlang noted. "There are, however, a number of attorneys representing physicians who would say that the administrative subpoena is inadequate and that maximum protection for the physician is derived from a court order directing release of the records. This is an area where there may be some disagreement between DCFS and attorneys representing physicians."

Such rifts are rare, however, Cotton said. "The vast majority of physicians are extremely cooperative with our investigations. Physicians are among the best groups we work with. We all recognize that what's most important is working together to make sure kids are safe."

State sues maker of herbal product

[CHICAGO] In mid-October, Illinois and six other states filed a fraud lawsuit against a company for marketing an herbal product containing ingredients associated with heart attacks, strokes, seizures and death.

The suit names Global World Media Corp., of Venice, Calif., and its president, Sean Shayan, as defendants in the sale of Herbal Ecstasy. The suit charges the defendants advertised a pill that contains as its main ingredient Ephedra, a botanical source of ephedrine alkaloids,

which are stimulants that can harm the nervous system and the heart.

"We are alleging that the company, attempting to profit from the sale of this product, made statements about Herbal Ecstasy, some of which could have had deadly consequences," said Illinois Attorney General Jim Ryan. "Since 1993, the FDA has received more than 800 reports of illnesses and injuries from the use of dietary supplements containing ephedrine alkaloids."

The Illinois Department of Public

Health is also pursuing the case and is targeting the marketing of an unapproved drug, while Ryan's office focuses on consumer fraud.

Ryan is seeking an injunction barring the defendants from selling Herbal Ecstasy until it complies with state consumer and food and drug laws. The company is charged with violating Illinois' consumer Fraud and Deceptive Business Practices Act and the Illinois Food, Drug and Cosmetic Act by selling an unapproved drug.

Other states that have joined the suit are Arizona, California, Minnesota, Pennsylvania, Texas and Wisconsin. ■

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This information, published as space permits, is reprinted from the Illinois Department of Professional Regulation's monthly disciplinary report. IDPR is solely responsible for its content.

July

David Richard Lewis, Elgin – physician and surgeon license placed on probation for three years and fined \$2,000 due to inappropriate examinations of two female patients without securing their consent to the procedures.

Jose P. Libunao Jr., Algonquin – physician and surgeon license placed on probation for one year for overprescribing controlled substances for an emergency room patient treated on multiple occasions.

Vidal C. Limpin, Lincolnwood – physician and surgeon license and controlled substance license indefinitely suspended to be followed by indefinite probation for voluntarily withdrawing from the Medical Assistance Program of the Illinois Department of Public Aid in 1993, which subsequently denied his petitions for reinstatement in 1994 and 1996.

Teddy Gonzalo Montoya, Chicago – physician and surgeon license placed on indefinite probation due to an outstanding tax liability owed the Illinois Department of Revenue.

Robert Joseph Olk, Chesterfield, Mo. – physician and surgeon license suspended for two years followed by probation for three years after pleading guilty to one count of felony tax evasion and one count of felony mail fraud in U.S. District Court in Missouri.

Walter P. Shemerdiak, Chicago – physician and surgeon license placed on indefinite probation and controlled substance license indefinitely suspended after pleading guilty to two felony counts of illegal possession of controlled substance and one misdemeanor count of driving under the influence and being sentenced in Cook County Circuit Court to court supervision for two years concurrent with probation for two years.

David J. Stinson, Rockford – physician and surgeon license reprimanded and fined \$1,000 for inadvertently and unintentionally breaching doctor-patient confidentiality.

Ellis J. Talbert, Oak Brook – physician and surgeon license reprimanded for pre-signing blank prescription forms on several occasions that were filled in by non-physician HMO staff.

Robert E. Vigasaa, Terre Haute, Ind. – physician and surgeon license indefinitely suspended after felony convictions of money laundering and mail fraud in federal court.

August

Richard G. Banta, Rockford – physician and surgeon license indefinitely suspended for violating the terms and conditions of a previously ordered probation.

Donja Galich Barr, Joliet – physician and surgeon license placed on indefinite probation after being convicted of mail fraud and conspiracy to commit mail fraud.

Zaher Boctor, Evergreen Park – physician and surgeon license reprimanded for failing to notify a patient on a timely basis that a pathology report had indi-

cated a vasectomy performed by him had been unsuccessful.

Frank O. Becker, Monee – physician and surgeon license restored to probation.

Rick Cernovich, Kewanee – physician and surgeon and controlled substance licenses placed on probation for one year after he obtained controlled substances from a hospital pharmacy to dispense to a patient outside the hospital without filling out a proper prescription form.

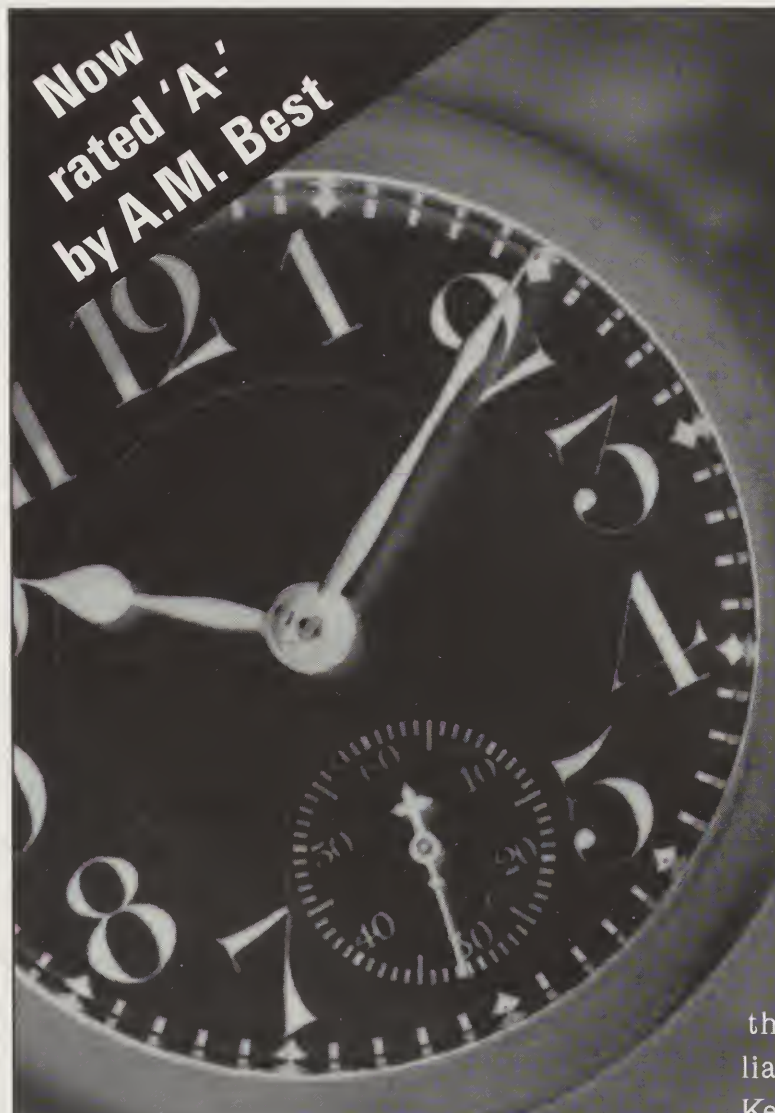
Richard S. Cook, Chicago – physician and surgeon license restored to probation for two years.

Ronald Meyer, Roanoke – physician and surgeon and controlled substance licenses placed on probation for two years and fined \$1,000 for not properly monitoring the prescribing of controlled substances to a number of his patients, and, for the purpose of treating his medical condition, consuming some controlled substances that he had prescribed for his son's medical condition.

Arvindbhai Patel, Des Plaines – physician and surgeon license placed on probation for two years and fined \$1,000 for not obtaining adequate diagnostic

verification prior to performing a modified radical mastectomy and failure to properly communicate surgical results to his patient.

Robert John Prentice, Galesburg – physician and surgeon license placed on probation for two years and controlled substance license placed on probation for three years for prescribing controlled substances for other than medically accepted therapeutic purposes, and not adequately considering and discussing with his orthopedic patients treatment options for long-term pain management other than the prescription of controlled substances.



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Balanced budget

(Continued from page 1)

for at least 10 years, according to the ISMS analysis. Those with three convictions can be permanently excluded. For anti-kickback offenses, convicted individuals or entities can be penalized up to \$50,000 per violation plus up to triple the damages, based on the remuneration offered, paid, received or solicited, according to the August 1997 Health Care Law Update from the Chicago-based law firm Sonnenschein Nath & Rosenthal.

Bruce Blehart, an attorney with the AMA general counsel's office, said it can be a challenge for physicians to learn who has been excluded from Medicare. Even when a HIPAA-mandated database

for such information begins operation, many questions about carrying out this provision must be answered as the regulations are developed, he said. For example, how often should physicians check the database? And if HHS accidentally omits a company or individual from the database, will physicians be sanctioned anyway because they should



Dr. Kobler

have known about the exclusion? "Those are the sort of questions we don't know the answers to," Blehart said.

The laws related to Medicare fraud and abuse can be confusing, Dr. Kobler said. "They seem to be reinterpreting some of the regulations and creating new problems by making up the rules as they go along in some circumstances."

The budget act also requires physicians to provide the Social Security and employer identification numbers for each entity with which they contract and for each individual who has at least a 5-percent ownership interest. HCFA will use these numbers to check for past fraudulent activities.

For payment of items or services to be made, physicians who place orders must give diagnostic or other medical information when the order is given, according to the ISMS analysis. The HHS secretary must issue written binding opinions to further explain which referrals for health services are prohibited under the Stark laws. ■

AMA offers assistance

As a starting point, the AMA is compiling a list of consultants to help physicians with implementation of the federal Balanced Budget Act's Medicare anti-fraud and anti-abuse efforts. The AMA has also developed a compliance plan that may help physicians avoid troublesome activities, said AMA attorney Bruce Blehart. The plan outlines the following seven steps:

- A clear commitment to compliance
- The appointment of a trustworthy compliance officer with a high level of responsibility
- Effective training and education programs
- Auditing and monitoring procedures
- Communications
- Internal investigation and enforcement
- A response to identified offenses that includes corrective actions

To get a copy of the compliance plan, call the AMA at (312) 464-4867.

ISMS Board of Trustees supports Rockford collective bargaining move

ACTION: Committee to study physician representation.

BY LINDA MAE CARLSTONE

[CHICAGO] The ISMS Board of Trustees offered formal support to Rockford physicians who are forming a collective bargaining unit. At its Oct. 25 meeting, the board agreed to "endorse in concept the Rockford Physicians' Council and its efforts to achieve a strong, independent voice for the physicians it represents, toward furthering the goal of high-quality patient care and preserving patient-centered physician advocacy." The board also commended the physicians for bringing this issue forward and working for physician autonomy and patients' access to quality medical care.

The council — a self-governed organization for physicians employed by Rockford Health Systems — aims to improve working conditions and patient care by negotiating solutions with the system. The group has been campaigning for support from non-management physicians to form a legally binding collective bargaining unit and has begun planning an election on the collective bargaining decision. A majority vote in support of collective bargaining would legally bind RHS to negotiate with the council.

Dennis Norem, MD, the RHS employee and an ISMS 12th District trustee, praised the board for trying to help physicians deal with the problems they face in medicine today. "The board recognizes that circumstances are different, and if physicians are employed, they may need to function under a collective bargaining umbrella to effect positive change for many issues, most importantly patient care," Dr. Norem said. The action clearly shows the Society has the vision to help physicians respond to change in a positive way, he said. "This is a good example of foresight in overcoming some of the traditional reservations people may have about collective bargaining relationships," he added.

At the October meeting, the trustees also agreed to study physician advocacy and representation and how ISMS might best represent all its physician members. Board Chairman M. LeRoy Sprang, MD, will appoint a committee to study these issues and issue a preliminary progress report to the ISMS House of Delegates in April 1998. ■

Hepatitis B

(Continued from page 1)

ule mandated by IDPH. The three-series vaccine will be required next year for all children entering fifth grade and youngsters over the age of 2 who are enrolled in prekindergarten programs. But in 1996 only 10 cases of Hepatitis B were reported among the 2.2 million children under the age of 14, Rothschild said.

"Obviously, the department didn't do

as well as it could have in explaining why Hepatitis B is included in the immunization schedule," said IDPH chief of communications Tom Schafer. "That's why we had trouble with the Legislature last year and why we're having the hearings now." Some parents don't understand why their children who aren't in the high-risk categories must be immunized, he said, adding that IDPH tries to do what's best for the state as a whole and for all children in the state.

The department developed the requirement through the rule-making process. IDPH is more than willing to incorporate suggestions to improve the vaccine scheduling process, Schafer said.

Even though parents were expected to comply with the immunization schedule in time for the current school year, IDPH delayed enforcement of the vaccine because of the complexity of the three-shot series.

Vaccines have effectively reduced disease in Illinois, according to IDPH Deputy Director David King. For example, in 1969, the first year the measles immunization was required for children entering Illinois schools, the number of measles cases reported in Illinois was 1,746, according to IDPH. But in 1996 there were only three known cases.

Vaccine regulations will likely become more complex in the next decade, as many new vaccines parade onto the market, said John Livengood, MD, director of the epidemiology and surveillance division of the national immunization program at the U.S. Centers for Disease Control and Prevention.

The Hepatitis B mandate has spurred interest in the broader issue of how immunization requirements are set, said Sen. Kathleen Parker (R-Northfield), who attended the hearing. "People were concerned that young children must be injected with the vaccine, and they think it's the state Legislature making the decision. That's not true."

The advisory board is planning hearings on Dec. 11 and possibly in February or March to gather more information before making recommendations to IDPH, according to ISBH Chairman James McGee, MD. ■

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PAGE 7

Illinois Medicine

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HMO premium hikes signal changes to come

FORECAST: As prices rise, so will expectations, experts say. BY LINDA MAE CARLSTONE

[CHICAGO] After several years of relatively flat rates, HMO premiums nationwide are expected to leap by anywhere from 5 percent to 9 percent in 1998, a shift that could force employers to try to negotiate or make changes in the coverage they offer employees. A report of 2,200 health plans nationwide conducted by the Lincolnshire, Ill.-based benefits consulting company Hewitt Associates showed that HMOs asked for increases ranging from 9 percent to 14 percent but settled at about 5 percent after negotiations.

The same forecast applies to Illinois, according to Chuck Sherfey, a senior consultant with the Chicago-based consulting company Coopers & Lybrand. "The 1998 rates are going to be up substantially from prior years. I've seen some in the 8 percent to 10 percent range,

[and] some with no increase. Illinois is not too different from the rest of the country."

At one of the state's largest HMOs, United HealthCare of Illinois, premiums will increase an average of 5 percent in 1998, according to a company spokesperson. The HMO's 1996 rates averaged only 1.7 percent higher than those for the preceding year, according to ISMS' 1997 Guide to Illinois Health Maintenance Organizations.

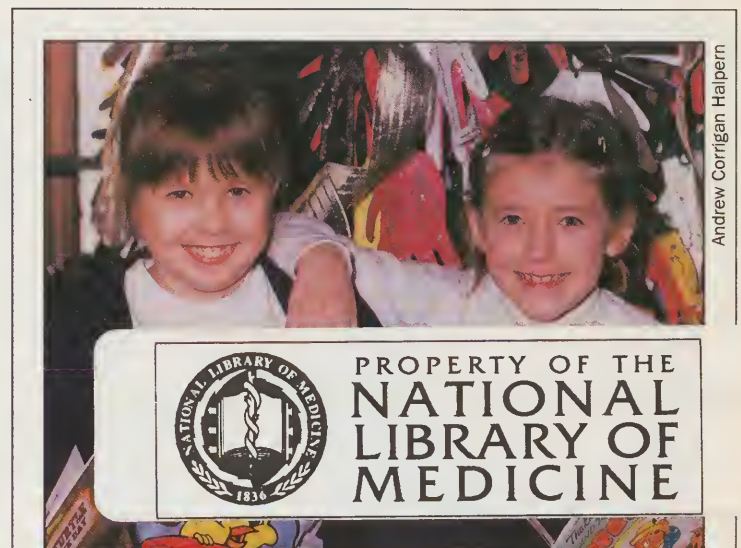
Employers who pay the bulk of the premiums as employee benefits will be among the first to feel an impact from the upward trend, which will likely continue after next year. Corporate planners, lulled by several years of insignificant rate increases, were jolted by the acceleration, according to Scott Ziemba, health specialist in the Chicago office of Watson Wyatt Worldwide, an employee benefits consulting

company. "Some of them budgeted only 2 percent increases."

The impact could stretch beyond pocketbook concerns to provoke broader changes in the already volatile managed care industry, experts said. "The price increases will trigger buyers to undergo a rigorous analysis of their HMOs," Ziemba said. "They will ask, 'If we are going to pay 8 percent more, is this the HMO we really want?'" Some employers will respond by switching to a cheaper competitor, he said.

But "the majority of employers will grit their teeth and take the increase," said Hewitt Associates consultant David Fortosis. "People get comfortable with their doctors and clinics, so employers don't have the courage to uproot those relationships."

Ziemba said he advises employers against shopping around. "A lot of employees



JULIA JOURAVEL (LEFT) AND MARIA BOBEL take a break from decorating Christmas trees at the John Hancock Center on Dec. 2 in Chicago. The girls were among more than 150 children whose handiwork was later displayed for patients at Children's Memorial Hospital.

Andrew Corrigan Halpern

have just gotten used to operating within an HMO environment, and changing would cause a fair amount of disruption." Instead of switching plans, many employers will demand more for their dollars, he said. They want to get quality and access, and those demands will trickle down to physicians. "For the most part,

the medical standards are in place, and the HMOs won't be able to tell providers to 'practice more quality medicine,'" Ziemba said. But employers may well demand better service, he said.

Sherfey, whose clients are mostly in Illinois, said he hasn't seen employers shifting more of the premium burden onto em-

(Continued on page 11)

INSIDE

Resolve
to make life
easier in 1998



PAGE 5

1998 Medicare
payment schedule
released

PAGE 2

DEPARTMENTS

Classifieds8

Tort reform supporters react to ruling upholding Petrillo doctrine

ANALYSIS: Defendant physicians and their attorneys will have to revert to restricting their communication with other treating doctors. BY JANE ZENTMYER

[SPRINGFIELD] A child who suffered from asthma was admitted to a St. Louis hospital and two days after being discharged, died at home in Illinois. The pathologist's report said that the child had died of dehydration, but the physicians who had treated the youngster in the hospital believed that there must have been pulmonary problems. To help them make sense of the unexpected death, the doctors called the child's pediatrician in Illinois and asked her to send them some of the patient's medical records. The pediatrician complied with the request. But later, the child's family sued the pediatrician, and the plaintiff attorney asked the court to enter discovery sanctions because records had been released to

other treating physicians in violation of the Petrillo doctrine.

This story, recounted by Jeffrey Glass, a partner in the Belleville law firm Hinshaw & Culbertson, shows how problematic the Petrillo doctrine has been for physicians and their defense attorneys.

Petrillo bars communication between defense attorneys and plaintiffs' treating physicians other than defendants if that communication occurs outside the normal discovery process. "It's what I call the Petrillo death penalty," said Robert Chemers, an attorney with the law firm of Pretzel & Stouffer in Chicago, in describing how the doctrine affects the defense in medical malpractice cases. Chemers was a member of the defense team in Kunkel vs. Walton, a case in

which the plaintiff sought to reverse changes to the Petrillo doctrine that were enacted in the 1995 tort reform law.

The Illinois Legislature modified and clarified Petrillo with H.B. 20, the comprehensive tort reform law that required plaintiffs to authorize the release of their medical records to defendants within 28 days. If they failed to do so, defendants could request a court order to obtain the records or have the case dismissed. On Nov. 20, the Illinois Supreme Court ruled in

the Kunkel case that the reforms were unconstitutional because they violated the separation of powers doctrine and invaded plaintiffs' privacy.

Separation of powers, the court argued, prohibits the Legislature from passing laws in areas that conflict with existing court rules. "This court retains primary constitutional authority over court procedure," wrote Justice John Nickels in the court's 6-0 decision, citing the precedence of court rules on

(Continued on page 11)

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GROVER SLOAN, MD (left), accepts congratulations from Charles Seten, MD, and Dr. Seten's wife, Nancy, at a reception Nov. 1 honoring Dr. Sloan for his 40 years of medical practice. Dr. Sloan is a family physician in Carrier Mills.



Cesar Maragni

HCFA releases 1998 Medicare fee payment schedule

CHANGES: Federal law calls for one-year delay in implementing resource-based practice expense values. BY JANE ZENTMYER

[WASHINGTON] The U.S. Health Care Financing Administration will implement its 1998 Medicare fee payment schedule Jan. 1, according to rules published Oct. 31 in the Federal Register. The rules incorporate changes included in the federal Balanced Budget Act of 1997, such as a one-year delay in

implementing resource-based practice expense values and a return to a single conversion factor.

Once HCFA makes those and other changes, Medicare payments will increase the most for radiation oncology, with an 8.4 percent hike; psychiatry and radiology, 8.2 percent each; pathology, 8.1 percent; and hematology/oncology, 8 percent, according to an ISMS analysis. The greatest reductions will be for cardiac surgery, with an 8.8 percent decrease; thoracic surgery, 7.2 percent; neurosurgery, 5.9 percent; ophthalmology, 5.8 percent; and plastic surgery, 5.3 percent.

These fee adjustments are modest, said John Schneider, MD, chairman of ISMS' Third Party Payment Processes Committee. "The major concern of physicians, particularly specialists, is the impact of a final decision on the resource-based practice expenses," he added. If Congress hadn't imposed the one-year delay on the new practice expense values, some specialties would have experienced drops of more than 10 percent in 1998, according to another ISMS analysis.

HCFA must use the delay to develop new practice expense values that take into account such factors as staff, equipment, supplies, data on equipment utilization, and consultations with physician organizations about methodology and data, according to an ISMS analysis. Congress must be given a report on the new values by March 31, 1998.

The new values will be phased in from 1998 to 2002. When fully implemented, the resource-based values are expected to shift more money to office-based services from all other services.

The practice expense value is one of three factors used to calculate physician payments, and it accounts for about 41 percent of the total Medicare payment, an ISMS analyst said. The value associated with work accounts for about 45 percent of the Medicare formula, and the remaining 4 percent or 5 percent relates to professional liability insurance expenses. These three areas — practice, work and liability — are adjusted by the Geographic Practice Cost Indices to reflect variations in operating costs in each Medicare fee area compared with the national average.

A 1998 update of the GPCI also contributed to changes in this year's fee schedule. Three Illinois regions — Cook County, the East St. Louis area and the rest of Downstate Illinois outside of the Cook County collar counties — are among the top six areas in the nation with the highest increases. The collar counties are the only area in Illinois to experience a slight reduction, according to the ISMS analysis.

Once a total value combining practice, work and liability expenses is calculated for a physician service, HCFA uses a conversion factor to transform it into a dollar figure. Previously, HCFA used three factors — primary care, surgical and all other services — to calculate payments. But the Balanced Budget Act requires only a single factor, which will contribute to increases for office-based practices and reductions for surgical practices, according to the ISMS analysis. ■

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Kane County Medical Society works to reduce drunken driving

COMMUNITY EFFORT: Group uses simulations, slides of accident scenes to bring about change. BY JANE ZENTMYER

[GENEVA] Even with Illinois' law lowering the legal blood alcohol level for drivers from .10 to .08, Kane County officials are looking for more ways to discourage drunken driving. In fact, the Kane County Medical Society has joined those working to resolve a growing problem in the county, said county society President Andrew Kramer, MD.

Dr. Kramer, a general surgeon, said he chose to focus on this issue during his year as KCMS president because of his experiences treating drunken patients involved in auto accidents. "In spite of efforts to reform these patients, the success rates are low," Dr. Kramer said. "The most significant issue is that these patients who I am trying to care for in a compassionate manner could be the very ones who continue driving drunk and cause children's deaths."

To tackle the issue, Dr. Kramer formed a task force that includes representatives of such groups as the National Highway Transportation Board, Mothers Against Drunk Driving, the Kane County Board of Health and the Kane County Sheriff's Department. Dr. Kramer said that by drawing these people together, he hopes to generate ideas to help reduce drunken driving.

After the task force's first meeting, Dr. Kramer learned that another anti-drunken driving task force – the Kane County Task Force on Drinking and Driving – was working on the same problems. Since then, the groups have joined forces. "It's good that the [county] medical society is involved in an issue that's affecting this county quite a bit," Dr. Kramer said. "If we can save some lives by solving this problem, we can give something back to the community."

In 1996, the number of deaths attributed to Kane County drunken-driving-related crashes jumped to 25 from the previous year's 16, according to the Kane County Coroner's Office. In 1994, there were 17 deaths; in 1993, there were 14; and in 1992, there were 21. The number of Kane County DUI arrests has slowly risen, according to the Illinois Secretary of State's Office. In 1995, the most recent year that numbers were available, 1,269 DUI arrests were made, an increase from 1,248 in 1994.

With those statistics in mind, the newly expanded task force is focusing on education. For example, law enforcement officers are visiting high schools and administering field sobriety tests to

students, giving them goggles that simulate an illegal blood alcohol level, said task force member Sgt. Donald Kramer. "It gives them an opportunity to feel the effects without actually getting drunk."

The task force has also conducted random sobriety tests at roadblocks and

set up Breathalyzer blood alcohol level testing devices at bars so that patrons could test their intoxication before leaving, the sergeant said. In addition, the group has placed "Don't drink and drive" signs throughout the county. As Dr. Kramer explained, "We are not trying to stop people from enjoying the attractions of alcohol, but we are trying to save lives."

Kane County Coroner Mary Lou Kearns said she joined Dr. Kramer's DUI task force to work toward "death prevention by education." For some time, she has traveled to area high schools to show slides of actual alcohol-

related accidents. "It doesn't necessarily have to be a driver who was intoxicated or drinking. It could have been somebody in the wrong place at the wrong time – a pedestrian hit by a drunken driver, a passenger who was killed. It could have been young kids who were bicycling and struck by a drunken driver." The visuals make an impact, Kearns added. Thirty-year-old adults ask her whether the program still exists, because they remember it from their teen-age years and hope their own children can learn from it. "It hits home that this happens right here in Kane County," Kearns said. ■

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EDITORIAL

Looking for the whole picture

Performance ratings, like some Christmas presents, may be easier to give than to receive. The Illinois Association of HMOs got what it perceived as a stale fruitcake last month when the National Committee for Quality Assurance released a prototype report card on eight Chicago HMOs. IAHHMO opposed the release of the report to the media and the public, saying that it was an incomplete version of NCQA's Quality Compass, a database of information on 329 managed care plans, according to Modern Healthcare magazine.

The Illinois HMOs listed in the report slightly underperformed when compared with national and regional averages in four of five categories – child immunization, breast cancer screening, cervical cancer screening and the percent of members seen by a provider, reported Crain's Chicago Business. But the Illinois plans scored higher than the national average in the fifth category, prenatal care.

Ironically, in the spring 1996 issue of IAHHMO's newsletter, the group's medical director wrote, "During IAHHMO's leadership meeting with the Chicago Tribune's editorial board, we were pointedly asked how we monitored managed care organizations. We could, with significant satisfaction, point to NCQA's development from within our industry."

The subject of disclosure also stirred things up at Illinois Senate hearings this fall. At one, business groups called for a directory of data about physicians, includ-

ing a history of malpractice litigation and claims. But such information needs to be put in context. Studies have shown that being sued for malpractice can have more to do with bad outcomes and deficient communication than negligence.

At another hearing, some representatives of managed care organizations said that accreditation groups like NCQA and the Joint Commission on the Accreditation of Healthcare Organizations do a good job of ensuring that MCOs follow industry standards, so it isn't really necessary to legislate reforms. But NCQA and JCAHO are funded by the entities that adopt their standards, and compliance is voluntary.

Of course, reports from these accrediting organizations are valuable, but they give limited information. For example, a year ago Michael Reese Hospital and Medical Center was warned that it would be banned from doing business with Medicare recipients unless it corrected numerous problems, according to the Chicago Tribune. An inspection by the Illinois Department of Public Health had revealed troubling quality-of-care problems including delays in defibrillating patients after cardiac arrest. Yet, only a month before problems were spotted, the Joint Commission granted the hospital its highest possible recommendation.

Accreditation information is useful, but it doesn't portray the whole picture. That's one reason ISMS will continue to work for managed care reform.

PRESIDENT'S LETTER

A Christmas gift

Jane L. Jackman, MD



All of you have stories about patients facing terminal illness. Carol taught me to remember life's real priorities.

Medicine is a most privileged profession. What other job pays us for interacting with people and gaining their trust and friendship while practicing the healing arts? All of us learn a lot about life and the human condition from our patients. I'd like to share a story about one of my patients with you as a gift at this holiday season.

Carol was a strikingly beautiful 63-year-old blonde who defied her age with her willowy figure (and the help of a facelift). A businesswoman with three grown children from a previous marriage, she was now happily remarried and filled her days with aerobics classes, volunteer work and friends. Her nagging backache was worrisome, but she laughingly attributed it to old age. However, her X-rays were reassuringly normal, and she agreed to try ibuprofen for a couple weeks.

Two months later, she called my office and said the back pain was more intense and she could hardly get out of bed. Later that evening, a concerned radiologist called me at home to report the metastatic cancer he saw on her CT scan. A few days of inpatient X-rays, scans and biopsies revealed a cancer in her right lung, and she began radiation treatment on her spine. Like many others faced with a life-threatening illness, Carol elected to undergo chemotherapy.

So began three months of chemically induced fatigue, nausea and weight loss, but Carol remained optimistic. Of course, her beautiful blond hair became thinner and then nonexistent. Her sister wanted to buy a wig for her, but Carol thought it was an extravagance until she found out what the treatment would do. "You should buy two – one blond and one red, just to keep your husband guessing," I joked. They took my advice, and Carol once again had beautiful hair and makeup.

Fall turned to winter. Carol required larger doses of morphine

just to sleep at night. In mid-December, the dreaded lack of bladder control developed, and she was readmitted for more radiation. One morning she said she needed to talk. I sat down on her bed. "It's not working, is it?" she asked, looking directly into my eyes. "No, Carol, the cancer is coming back, and I don't think we can cure you," I admitted sadly. "Then I'm going home," she determined. "I rolled the dice and lost, and I want to die in my own home."

The next morning, Carol was on the phone, commanding her troops like the seasoned general that she was. This was to be the best Christmas ever for her – no tree, no presents, no cooking or cleaning – just time to sit and talk and appreciate her family. One son was ordered to pick up Christmas Eve dinner from a restaurant, another to get the special Christmas bread and desserts from a bakery, and her daughter to provide transportation home. Carol admitted to me that she had always been so busy making Christmas perfect for others that she never had time to enjoy it herself.

Christmas came and went. Over the next weeks, Carol spent more time sleeping as she became weaker. The wigs and makeup gave way to wispy gray hair and the au naturel look. She died well-cared for, surrounded by her loved ones and still beautiful.

All of you have stories about patients facing terminal illness with courage and grace. However, Carol taught me to remember life's real priorities. At the time I was a harried mother of four young children, and like Carol, I tried so hard to be supermom that I rarely enjoyed the holidays for what they were meant to be. As doctors, we have the most demanding profession; we constantly give ourselves to our patients in terms of our time, caring and compassion. Yet our families and friends need us also. As Carol found out, they are the most important part of our lives. In this season of giving, I hope all of us can give the gift of time to our loved ones. A joyous holiday season to all of you!

GUEST EDITORIAL

Get ready for 1998

It's that time of year when we need to think about those pesky New Year's resolutions. Here are some that may help make your life a little easier in 1998:

1. Prepare your practice for the 1998 Medicare fee schedule and watch the debate unfold as the U.S. Health Care Financing Administration compiles new practice expense values to be implemented in 1999. HCFA wants input from physicians about what should go into those new values.

2. If you haven't done so already, submit the paperwork to the Illinois Department of Professional Regulation for your new controlled substance license numbers.

3. Expand your documentation for Medicare claim forms as required by new rules put in place by HCFA. The forms now require more-specific descriptions of why a procedure was performed, according to Medicare officials.

4. Be sure to fulfill the 50 hours of CME now required as part of renewing a medical license in Illinois. Keep abreast of what qualifies as CME when IDPR releases rules in 1998.

5. Explore different avenues for CME, such as the ISMS Alliance's program in identifying and treating the victims of domestic violence.

6. Next year is an election year, so contribute to the Illinois State Medical Society Political Action Committee and help elect physician-friendly legislators. Go to the polls for the March 17 primary and the Nov. 3 general election.

7. Help legislators and other leaders become more physician-friendly by showing them how you work and what issues you deal with every day. Participate in an ISMS Alliance mini-internship.

8. Educate yourself as much as possible about what constitutes Medicare fraud and abuse, since the federal government plans to stiffen its crackdown. You don't want to be penalized for contracting with an organization that has a sullied record, for example.

9. Regularly attend meetings of your county medical society so you can help shape its and ISMS' policies and positions.

10. Stay up-to-date on managed care changes, trends and how-to information. A good place to start is ISMS' Guide to Illinois Health Maintenance Organizations. Before you sign any managed care contracts, read them carefully or ask your attorney to review them.

11. If you're an ISMS delegate or voting member, submit resolutions for the 1998 Annual Meeting by the close of business on March 24. Attend the meeting a month later, April 24-26.

12. Avoid lawsuits by attending an ISMS risk management seminar. Watch Illinois Medicine for dates and locations.

13. Advocate for your patients in the managed care environment. When a comprehensive bill that's good for patients is pending, write or call your legislators and ask them to support it.

14. Let your patients know about new, free services like the Friend-to-Friend Illinois Women's Health Campaign program.

15. Help improve public health and public relations by taking part in the ISMS Speakers Bureau, which sends doctors to schools and community groups to talk about health issues.

16. Check out ISMS' Web site at www.isms.org. Explore the Internet because this technology offers clinical and practice management information, and provides your patients with a lot of

medical information with varying degrees of quality.

17. Donate to the ISMS Student Loan program and support other physicians as they build their careers.

18. Volunteer a few hours in a free clinic. There are more than 20 in Illinois, and one is within an hour or two of nearly every Illinoisan.

For more information about any of the ISMS or ISMIE programs mentioned, call (312) 782-1654 or (800) 782-ISMS.



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REPORT for Illinois Physicians

MEDICARE COLORECTAL CANCER SCREENING

The following screening tests for colorectal cancer become effective January 1, 1998: screening fecal-occult blood tests, screening flexible sigmoidoscopy, screening colonoscopy, and screening barium enema.

Screening fecal-occult blood tests are covered at a frequency of once every 12 months for individuals who have attained age 50. Payment for this test will be paid at the same amount as diagnostic fecal-occult blood test under the clinical laboratory fee schedule.

A screening flexible sigmoidoscopy is covered at a frequency of once every 48 months for individuals who have attained age 50, and will be paid at the same amount as diagnostic flexible sigmoidoscopy. If during the course of the screening flexible sigmoidoscopy a lesion or growth is detected which results in a biopsy or removal of the growth, the procedure code for a flexible sigmoidoscopy with biopsy or removal of lesions would be reported rather than the code for a screening flexible sigmoidoscopy.

A screening colonoscopy is covered at a frequency of once every 24 months for individuals at high risk for colorectal cancer, and will be paid at the same amount as diagnostic colonoscopy. The law defines high risk as a person who, because of family history, prior experience of cancer or precursor neoplastic polyps, a history of chronic digestive disease condition (including inflammatory bowel disease, Crohn's disease, or ulcerative colitis), the presence of any appropriate gene markers for colorectal cancer, or other predisposing factors, faces a high risk for colorectal cancer.

A screening barium enema may be substituted for either a screening flexible sigmoidoscopy or a screening colonoscopy if an individual's physician has determined that the screening barium enema will be as effective as the screening flexible sigmoidoscopy or screening colonoscopy for that individual. Payment will not be made for both a screening barium enema and a screening flexible sigmoidoscopy for an individual who is not at high risk for colorectal cancer during the same 48-month period, nor will payment be made for both a screening barium enema and a screening colonoscopy for an individual who is at high risk for colorectal cancer during the same 24-month period. However, if a barium enema is positive, a colonoscopy would follow and would be covered because it is not a screening colonoscopy. The limit of one procedure in 48 months is a limit of one screening procedure.

Coming soon:
update on the
statute of
limitations for
minors

ISMIE Update

ISMIE offers post-trial resources

Through policyholder surveys, evaluations of the medical facts and risk management seminars, ISMIE provides follow-up. BY JANE ZENTMYER

When she heard the jury foreman read the verdict of not guilty at her medical malpractice trial, Chicago Ob/Gyn Eileen Collins* was greatly relieved. Her four-year ordeal – stemming from a lawsuit by a former patient for failure to diagnose breast cancer in a timely manner – had consumed Dr. Collins' time and energy and taken her away from her

completed was one of three sent to her and to most policyholders involved in litigation; the other two surveys ask similar questions but are sent at earlier stages. (Depending on when claims close, some policyholders may get two surveys.) Cumulatively, the surveys give policyholders an opportunity to rate ISMIE service throughout the entire process.

money had been spent on her defense, the lawsuit wouldn't cause a rate increase, because the verdict was positive. To determine rates, ISMIE considers the number of claims filed against a policyholder over time, also known as frequency, and the costs related to a settlement or judgment, also known as severity.

If Dr. Collins' claim had resulted in a payment either through a jury verdict or a settlement, the case would have been reviewed by ISMIE's Physician Review and Evaluation Panel. "We make assessments as to the medical judgment that's been exhibited in the handling of the cases in question and make a recommendation relative to whether the policy represents an undue risk to the company or not," said the chairman of PREP.

The nine-member panel uses physician consultants in the policyholder's specialty to review the medical facts. PREP members consider those reviews and make such decisions as whether policyholders should be required to attend ISMIE risk management seminars or take a CME



Petrified Collection/Image Bank



G. & M. David DeLossy/Image Bank

practice and her family. As her life slowly returned to normal during the first few weeks after the trial, Dr. Collins reflected on her experience and started searching for ways to avoid being sued again.

When a survey arrived from her insurer, the Illinois State Medical Inter-Insurance Exchange, Dr. Collins expressed her satisfaction with the people with whom she had worked. She gave high marks to her professional liability analyst and her defense attorney for keeping her informed about her claim, answering her questions quickly and preparing her for trial. Dr. Collins said that if she faced another claim, she would like the same attorney and analyst. She also noted that she felt as involved as she wanted to be in choosing expert witnesses.

"We want the policyholders to give us insight on what worked for them and what didn't work for them. Sometimes they can tell us how we can make it better," said Harold Jensen, MD, chairman of the ISMIE Board of Governors. The ISMIE survey that Dr. Collins

Dr. Collins' experiences with ISMIE mirror those of other ISMIE policyholders, according to surveys sent between July 1995 and December 1995, the most recent time frame for which data is available. On average, physicians rated their overall satisfaction with their ISMIE team as a 9 based on a scale of 1 to 10, with 10 representing an extremely good job. About 90 percent of respondents said that if faced with another claim, they would prefer the same professional liability analyst and defense attorney.

"We think we're doing a good job, but we want to know we're doing a good job," Dr. Jensen said. In fact, survey responses are taken so seriously that ISMIE has severed some working relationships because of them, he added. Policyholders who ask questions on their surveys will get a follow-up phone call from ISMIE representatives, as Dr. Collins learned after querying whether her lawsuit would cause her premiums to increase.

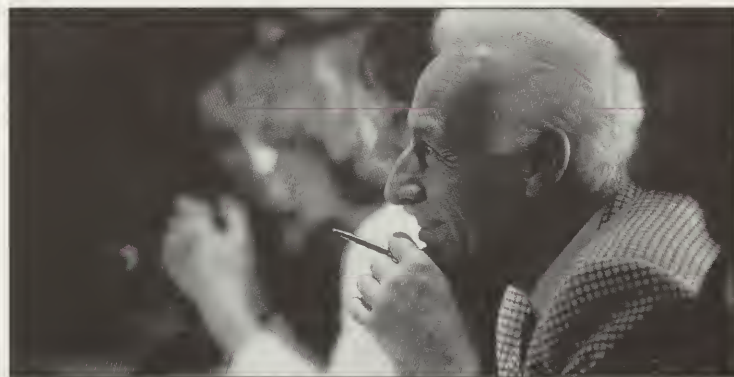
A call from ISMIE reassured Dr. Collins that even though

course, the chairman said. Occasionally, surcharges are levied against physicians to heighten their awareness of the costs associated with litigation.

In extreme cases, ISMIE may cancel policies – for example, if physicians are named in an excessive number of claims or altered medical records after a claim was filed. Physicians can

appeal the decision, though, and make a personal appearance before PREP. "Our intent is to reduce the risk for all of us who hold policies with the company, so that we're not going to put in jeopardy the insurance that all of us have," the chairman said.

Dr. Collins was especially happy about the verdict because she knew that federal law requires all medical malpractice cases resulting in liability payments to be reported to the National Practitioner Data Bank. In addition, state law requires insurers to send a report with similar information to the Illinois Department of Professional Regulation.



G. & M. David DeLossy/Image Bank

Although Dr. Collins was pleased with the outcome of her case, she knew there were ways she could improve her procedures. Her attorney told her before trial that better documentation would have made the case easier to defend. For example, Dr. Collins had written "breasts negative" in the patient's medical records, a

point on which she was extensively questioned by the plaintiff attorney. Instead, she could have taken a little more time to write a complete notation. The jury would have found a written explanation more credible than Dr. Collins' recollections of events, her attorney explained.

To help Dr. Collins pinpoint which record-keeping procedures she could improve, she used an office self-assessment questionnaire from ISMIE. She was reminded that she needed to document all medically relevant telephone calls and make sure her charting was readable. Dr. Collins also chose to take the ISMIE seminar "Risk Management: An Essential Office Practice" to make doubly sure that her procedures wouldn't expose her to unnecessary liability. Dr. Collins found that she was doing well in follow-up procedures, patient education, medication control and billing procedures.

While working on her documentation skills, Dr. Collins decided to brush up on her patient communication skills and her clinical knowledge of her specialty. Those are three key areas, according to Dorothy French, a partner with the Lisle law firm Hinshaw & Culbertson. "If you have all three things – you communicate, you document, and you practice good medicine – you will be decreasing your risk of a lawsuit. And if a lawsuit does occur, it will most likely be defensible."

*This case is hypothetical.

Normand Cousineau/SIS



Free clinics support the medically underserved

The number of Illinois clinics is increasing, but so is the number of patients in need.

BY LINDA MAE CARLSTONE

Ubaldo Alonzo is long on ailments and short on work. Arthritis in his neck and back make it difficult for the Waukegan resident, a carpenter by trade, to lift heavy objects. "I don't have much income, because I can't take a lot of jobs," Alonzo explained. Yet, there was a smile on his face as he waited for his name to be called at the HealthReach free clinic. He said he's grateful there's a place where he can get treatment that asks for only a \$5 donation.

Similar visits have occurred more than 50,000 times throughout the state this year. More than 20 free clinics in Illinois provide a safety net for patients like Alonzo who have slipped through the health care cracks: They're not employed long enough to have health insurance and not poor enough or old enough to qualify for Medicare or Medicaid.

More and more people work at jobs that don't pay enough to allow access to health care, said free clinic advocate Alison Watkins, executive director of Community Health Care Clinic in Normal. "We get a lot of people who work at fast-food restaurants, beauty shops and department stores. They don't make enough to feed their families, house them and pay medical bills." To be eligible for care at the Normal clinic, a patient's income must be at or below 150 percent of the federal poverty guideline. That amounts to \$28,000 a year for a family of five, she said. "It doesn't go very far."

Many clinic patients have let a decade or more pass since their last health care visit, according to clinic organizers. "We see a lot of chronic illnesses," said Theresa Schroeder, executive director of the Morgan-Scott Volunteer Health Clinic in Jacksonville, the state's newest free clinic, which opened last summer. "These patients have been told they have a condition, but they have no money to take care of it. One woman who came to us is insulin-dependent and had not been to the doctor for diabetes in more than 10 years. She went untreated until the clinic opened."

THE NUMBER OF FREE CLINICS in Illinois has risen steadily from four in 1992 to more than 20. Established clinics provide inspiration and education for the newer ones, according to organizers. "When doctors in Jacksonville wanted to start a clinic, they came to the Springfield clinic for advice," said ISMS President Jane Jackman, MD, who was closely involved in the start-up of Springfield's HealthFirst Community Clinic. "There's no point for other clinics to reinvent the wheel."

In many cases, patients at free clinics receive services on a par with those offered to patients flashing an insurance card. Many clinics offer primary care on-site, handled by a staff of physician volunteers on rotating

schedules. Patients who need further care are referred to a network of local specialists who offer their services as needed. In addition, many free clinics are linked to area hospitals for extended services.

Despite the growing number of free clinics, the task of providing health care for the poor can be overwhelming, clinic advocates said. "They are beating down the doors," said Pamela Fletcher, HealthFirst's executive director. "The need is growing because of changes in how people qualify for medical assistance," she said. Watkins said the challenge will be to keep pace with demand as welfare reform strips more individuals from government programs. At the Normal clinic, patients must wait three weeks for an appointment.

Although free clinic administrators share ideas, no two Illinois free clinics are identical, said Dan Rodriguez, coordinator of the Illinois Free Clinic Network, which provides a sounding board for clinic sponsors to exchange information and solve problems. Twenty-three clinics are associated with the network, and there are even more groups that offer free or low-cost services, he said. The network defines free clinics as nonprofit organizations that provide services at little or no charge and that are staffed mostly by volun-

teers. Some charge small fees, which are waived if patients cannot afford to pay.

"Each clinic has its own board and its own mission" and tries to fit within the needs of the communities and the constraints of available resources, Rodriguez said. Accommodations vary, for example. Some clinics are housed for free in space provided by hospitals, churches or clinics, and others rent commercial quarters.

The patient base differs as well. Waukegan's patient roster includes the homeless, part-time and full-time workers, the unemployed and the undocumented. The Springfield clinic requires patients to be uninsured and low-income employees. Even with its working-poor restrictions, the Springfield clinic is able to serve only 2,000 patients from a pool of 27,000 people. "Our resources are so limited," Fletcher said.

Already overstretched resources can cause medication shortages. Most clinics redistribute samples from physicians, but the supply seldom meets the demand, Rodriguez said. "If we don't have what they need, we have to hand them a prescription and say, 'You're on your own.'" The clinic network is working on legislation that would extend to free clinics the public health discount on drugs that is

(Continued on page 8)

Free clinics cover the state

No matter where physicians practice in the state, there's probably a free clinic nearby that needs volunteers. The following are among the clinics in Illinois that provide free or low-cost health care to the poor:

Aurora
Kane County Health
Department Wellness Clinic
(630) 208-3801

Chicago

- Community Health Clinic
(773) 395-9900
- Franciscan Homeless Shelter
(773) 265-6683
- Pacific Garden Mission
(312) 922-1462
- St. Basil's Health Services
Free People's Clinic
(773) 436-4758

Chicago Heights
Family Health Society
(708) 754-0746

Danville
Vermilion Area Community
Health Center
(217) 442-9355

Dixon
Volunteer Care Center
(815) 284-9555

Elgin
Health Center of the
Community Crisis Center
(847) 741-3336

Freeport
Community Clinic
(815) 235-0116

Harvard
Family Health
Partnership Clinic
(815) 943-1021

Joliet
Will-Grundy Medical Clinic
(815) 726-3377

LaGrange
Community Nurse
Health Association
(708) 352-0081

McHenry
McHenry County Free
Health Clinic
(815) 385-9355

Normal
Community Health
Care Clinic
(309) 888-5532

Jacksonville
Morgan-Scott Volunteer
Health Clinic
(217) 479-5700

Peoria
Heartland Community
Health Clinic
(309) 673-9242

Pontiac
Livingston Family
Care Center
(815) 842-1441

Quincy
Community Outreach
Clinic
(217) 223-1200,
ext. 4117

Rolling Meadows
Neighborhood Health
Resource Center
(847) 670-1224

Springfield
HealthFirst Community
Clinic
(217) 753-0161

Waukegan
HealthReach Clinic
(847) 360-8800

Wheaton
DuPage Community Clinic
(630) 682-0639

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Free clinics

(Continued from page 7)

available to county health departments, he said.

Despite the limitations, volunteers keep the clinics operating. "In the three years we have been open, we have never had to cancel a clinic for want of a medical volunteer," Fletcher said. Dr. Jackman said she is amazed at how many volunteers step forward these days to meet the clinic's needs.

In return for their time and talent, volunteers receive fulfillment, Dr. Jackman said. "Most doctors go into medicine because they want to help people. Having a central place to volunteer appeals to most doctors because it makes it easier to do the altruistic thing they wanted in the first place." She noted other benefits: "The only people there are the ones who want to be there. And there's no insurance company looking over your shoulder saying you have to see a patient every 10 minutes."

Grayslake internist Oscar Giron, MD, who volunteers weekly at the Waukegan clinic, echoed Dr. Jackman's remarks, adding that "the patients are very appreciative. They come in dressed in their Sunday best."

Without motivated volunteers, free clinics couldn't function, Rodriguez said. "There are a lot of people – physicians, nurses, hospital personnel and business-people – all contributing a portion. Together, we get a lot done." ■

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HMO premium

(Continued from page 1)

ployees to make up for the increase.

But employers could choose to consolidate their health plans. "They might pick the two best [of three choices], because the rates will go down sometimes if the volume increases," Ziemba said.

In addition to generating better rates, consolidation is more efficient. Some large nationwide corporations work with hundreds of HMOs, Ziemba explained. If a corporation like that had only a handful of employees in, say, 45 plans, it would be very difficult to manage those relation-

ships. "So, [employers] get rid of the small ones and focus on the large ones so they'll have more clout at renewal time."

But consolidation makes the health care market even more competitive, and that tends to squeeze physicians tighter than ever, Ziemba said. "[Consolidation] puts HMOs in a position to cut payments to providers and tells them, 'If you don't like it, sorry.'"

One thing is fairly certain: The premium increases are unlikely to be passed along to physicians, said John Schneider, MD, chairman of ISMS' Third Party Payment Processes Committee.

If physicians share any piece of the

increase, it will have strings attached, Fortosis said. A few HMOs are offering to increase capitation rates to physicians who will track and report on procedures that will make the HMOs look good. "These may be tough things for physicians to do," he added.

Don't expect HMOs to suddenly withdraw their higher rate increases, though. A report by InterStudy, a St. Paul, Minn.-based company that studies HMOs, showed that family premium rates have held almost even since 1994, after steady growth in the early 1990s. The pending rate hikes represent a shift in strategy by HMOs, which used low prices to gain

market share, analysts said. "That strategy took a toll on a lot of HMOs. Now they're shifting to profitability," Ziemba said. In Illinois, 19 of the 33 HMOs doing more than 30 percent of their business in the state showed losses in 1996, according to the ISMS guide. HMO enrollment in Illinois decreased by about 172,000 from 1996 to 1997, according to InterStudy.

"Carriers are no longer willing to absorb the increases like in prior years," said Sherfey. "Their choice is to raise rates or suffer more losses while they try to increase their market share. I get the impression they're not willing to suffer any more losses." ■

Tort reform

(Continued from page 1)

matters within the court's authority.

The justice referred specifically to Rule 201, which outlines procedures related to discovery issues, according to ISMS General Counsel Saul Morse. "This decision raises the question of whether the Legislature can adopt anything in the area of access to information through discovery, which, if that's what the court is saying, is a major departure from precedent."

A 1986 appellate court decision originally established the Petrillo doctrine, Morse said. In that decision, the court said it would have to rule on when physician-patient confidentiality could be breached, because the Legislature had failed to legislate that distinction. "So, in the decision that caused this 1995 law, the court even said the Legislature hadn't acted and that's why they were going to — clearly raising in almost everybody's minds the belief that this had been an area the Legislature had historically acted on and could continue to act on," Morse said.

Rep. Tom Cross (R-Yorkville), a sponsor of H.B. 20, called the Supreme Court's decision on Kunkel vs. Walton "baffling," because the Legislature "created the patient-physician privilege, and then we created exceptions, [including] when you file a lawsuit, you waive that privilege."

The court also said physicians are privy to intimate details of their patients' personal lives and releasing information not relevant to the case would invade patients' privacy. Nickels wrote in the Kunkel opinion that the reforms to the doctrine require "a blanket consent to disclosure of all medical information without regard to the issues being litigated. The scope of the required disclosure is unreasonable and unconstitutional."

This is a new standard, Morse said. "Every day of the week lawyers file requests for any and all papers or records related to an issue. A lot of the material you get could never be introduced in court." The ruling raises the issue of whether plaintiff attorneys can now refuse to release medical records of previous injuries by arguing that those records are irrelevant to the current injury, Morse added. "Then the defense has to try to show that it's relevant, but they don't know what they're trying to show. They can't prove it's relevant until they get it."

Like ISMS, the Illinois Civil Justice League is disappointed in the ruling. Edward Murnane, president of the coalition that fights for tort reform, said the league "plans to go back to the drawing board and work with legislative sponsors to re-create language using the guidance that the court has provided." ■

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